Family planning programme implementation

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Differences in contraceptive prevalence rates across Local Government Authorities in Tanzania

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Mackfallen Anasel
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Abbreviations

CBD	Community Based Distribution
CCHP	Comprehensive Council Health Plan
CEDHA	Centre for Educational Development in Health, Arusha
CHMT	Council Health Management Team
CHPT	Council Health Planning Team
CHPT	Council Health Planning Team
CHSB	Council Health Board
COC	Combined Oral Contraceptive
CPR	Contraceptive Prevalence Rate
CTC	Care Treatment Care
CYP	Couple Year Protection
DAS	District Administrative Secretary
DC	District Council
DDH	District Designated Hospital
DHS	District Health Secretary
DMO	District Medical Officer
DRCHco	District Reproductive and Child coordinator
ECP	Emergency Contraceptive Pills
FBO	Faith Based Organisation
FGM	Female Genital Mutilation
FHI 360 Family	Health International
FMNCH	Family Planning, Maternal, Newborn and Child Health
FP TWG	Family Planning Technical Working Group
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HSSP III	Health Sector Strategic Plan III
ICPD	International Conference on Population Development
ID	Identification Number
IEC	Information Education and Communication
IUCD	Intra Uterine Contraceptive Device
LGA	Local Government Authority
M&E	Monitoring and Evaluation
MC	Municipal Council
MDGs	Millennium Development Goals
MoHSW	Ministry of Health and Social Welfare
MSD	Medical Store Department

NBS	National Bureau of Statistics
NFPCIP	National Family Planning Costed Implementation Programme
NFPRA	National Family Planning Research Agenda
NGO	Non-Governmental Organisation
NIMR	National Institute for Medical Research
NPTC	National Population Technical Committee
NUFFIC	Netherlands Universities Foundation for International Cooperation
POP	Progestogen-only Pill
PSI	Population Services International
RAS	Regional Administrative Secretary
RCH	Reproductive and Child Health
RCHco	Regional Child and Health coordinator
RHMT	Regional Health Management Team
RMO	Regional Medical Officer
SOPAM	School of Public Administration and Management
STI	Sexual Transmitted Infection
TACAIDS	Tanzania Commissions for AIDS
TCPD	Tanzania Council on Population and Development
TDHS	Tanzania Demographic and Health Survey
TFR	Total Fertility Rate
TPAPD	Tanzania Parliamentarian' Association on Population Development
UMATI	Family Planning Association of Tanzania
UNFPA	United Nations Fund for Population
UPT	Urinary Pregnant Test
URT	United Republic of Tanzania
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organisation
ZHRC	Zonal Health Resource Centre

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Chapter 1

Study overview

1.1 Introduction

In 2012, Tanzania was recorded to have a total population of 44,928,923, which presents a four times increase when compared to the 1967 population of 12,313,469 (Census Report 2012). Although the country as a whole is sparsely populated, there are still some areas where the population density is high. The high growth rate of the population in the country is caused by persistently high fertility and a declining mortality rate. Table 1.1 shows Tanzania's 45% youth population which has remained unchanged for more than four decades with a 92% age dependency ratio.[1] There are, however, substantial differences in dependency ratios across regions in Tanzania. The region with the highest ratio is twice as high as the region with the lowest. The three regions with highest age dependency ratio are Simiyu (119.7), followed by Mara (113.2), Geita and Rukwa (both 112.9). The three regions with lowest age dependency ratio are Arusha (81.5) followed by Kilimanjaro (81.4) and Dar es Salaam (50.8) (NBS 2013).

Table 1.1: Population growth trends, 1967-2012

Indicator	**Years**				
	1967	1978	1988	2002	2012
Total population	12,313,469	17,512,610	23,095,882	34,443,603	44,928,923
Average annual growth rates		3.2	2.8	2.9	2.7
Population density (pop. /km2)		20	26	39	51
Share of age group					
0 - 14		45	46	44.3	44
15 - 24		17.4	19	19.5	19
25 - 64		33.5	30.7	32.3	
65+		4.1	4.3	3.9	

Source: National Bureau of Statistics (NBS) 2013

1. 'Age-Dependency Ratio' is the ratio of people in 'dependent' age groups (those under age of 15 years and aged 65 years and older) to those in the 'working age population' (15-64 years). It is expressed as number of dependent per 100 working age populations. The age-dependency ratio is a proxy indicator of the economic burden and responsibility borne by the working age population: the ratios higher than 100 are undesirable. (NBS 2013).

The country still has a high fertility rate of 5.4, a number which has stayed unchanged for two decades. This is considerably higher than the world average of 2.4 (UN 2014). Despite a decrease in the mortality rate, it is still relatively high in Tanzania when compared with the world average. Whilst Tanzania has an infant mortality rate of 81 per 1,000 live births, the world average is 37. The improvement is observed in under-five mortality where the country has a relative low rate of 51 deaths per 1,000 live births against the world average of 52 deaths per 1,000 live births (UN 2013). The most substantial differences are observed in the maternal mortality rate where Tanzania has 454 deaths per 100,000 live births compared to a world average of 210 deaths per 100,000 live births (WHO 2014).

To address the persistently high rates of fertility, maternal mortality and child mortality, the World Bank recommended that the Tanzanian government broaden the use of contraceptives (Richey 2004). In 1989, the *National Family Planning programme* was launched. Three years later (1992), the *National Population Policy* (revised in 2006) was enacted with improvement of the standard of living as its central goal. The policy aims to achieve this through various means, one of these is the regulation of the national population growth rate by strengthening family planning services.

In order to realise the family planning programme goals in 1993 the 'Green Star' campaign was launched. The aim of the 'Green Star' campaign was to increase community awareness on family planning services. Numerous activities were put in place, including the famous radio advertisement *Zinduka,* and the radio drama *Twende na Wakati* (Piles and Simbakalia 2006). Following this, in 1998 the programme was incorporated into the broader category of Reproductive and Child Health (RCH). Between 1999 and 2007, the programme lost momentum due to a number of reasons: (1) the HIV/AIDS epidemic that shifted the attention of donors and (2) a loss of focus on family planning services after integrating the programme with RCH services at health facilities in all Local Government Authorities (LGAs).[2]

To relocate the family planning programme, the ministry of Health and Social Welfare (MHSW) introduced the *National Family Planning Costed Implementation Programme (NFPCIP)* 2010-2015 with the aim of increasing the Contraceptive Prevalence Rates (CPR) from 28% to 60% by 2015. Contraceptive Prevalence Rate (CPR) is the proportion of women of reproductive age (15-45 years) who are using (or whose partners are using) a contraceptive method at a given point in time. CPR is considered an indicator of health, population, development and women's empowerment (UN 2003). It also serves as an alternative measure of access to reproductive health services that is essential for meeting some of the Millennium Development Goals

2. http://www.rchs.go.tz/index.php/en/about-rchs/36-about-family-planning

(MDGs), especially the child mortality, maternal health, HIV/AIDS and gender related goals (Weinberger et al. 2013).

1.2 Contraceptive Prevalence Rate (CPR)

Despite the fact that the implementation of the National Family Planning programme and the National Population Policy began more than twenty years ago, Tanzania still has lower levels of contraceptive use than its neighbouring countries, lagging behind Kenya, Zimbabwe, Zambia, Malawi and Rwanda.[3] According to the 2010 Demographic and Health Survey (NBS 2011), only one-third of married women (34%) are currently using any family planning method: 27% use modern methods and 7% use natural (traditional) methods. The prevalence of contraceptive use is comparable to the prevalence levels in the other least developed countries, but is much lower than the worldwide average of 63% (Alkema et al**.** 2013).

Table 1.2 shows that in 2010, 35% of married women in the Tanzanian mainland and 18% of married women in Zanzibar reported using any contraceptive method. The figures in figure 1 show a wide range of CPR across Tanzania's regions (26 at that time). In Pemba Island North only 7% of the married women and in Zanzibar South 33% of married women were currently using contraceptives. In Tanzania's mainland, the region with the highest contraceptive use was Kilimanjaro region (65%) followed by Tanga region (54%). Mara was the region with the lowest contraceptive prevalence (12%) followed by its neighbours Mwanza region and Shinyanga region, each with 15%.

3. ICF International, 2012 http://www.statcompiler.com.

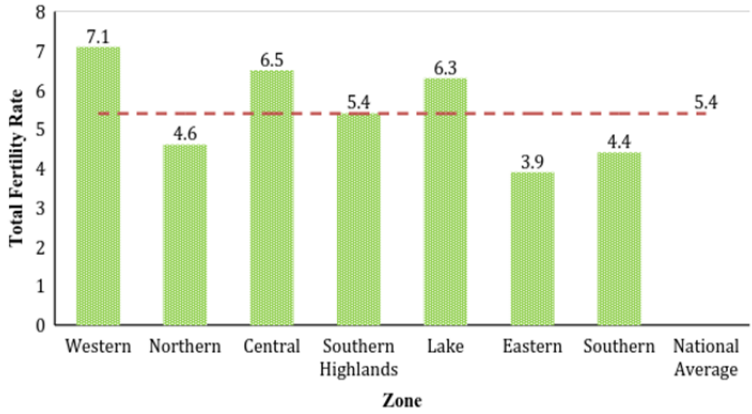
Table 1.2: Prevalence of Current married women age 15-49 years use any contraceptive by Zone and Regions

Zone	Prevalence %	Region	Prevalence %
Tanzania Mainland	*35*		
Western	20	Shinyanga	15
		Kigoma	25
		Tabora	26
Northern	49	Arusha	40
		Manyara	27
		Kilimanjaro	65
		Tanga	54
Central	29	Dodoma	29
		Singida	28
Southern Highlands	46	Rukwa	39
		Mbeya	49
		Iringa	45
Lake	18	Kagera	26
		Mwanza	15
		Mara	12
Eastern	48	Dar es Salaam	50
		Pwani	42
		Morogoro	47
Southern	42	Lindi	41
		Mtwara	38
		Ruvuma	47
Tanzania Zanzibar	*18*	Unguja North	11
		Unguja South	33
		Town West	26
		Pemba North	7
		Pemba South	11

Source: TDHS 2010

The available Zone Total Fertility Rate (TFR) data indicate that there are zones with a TFR above the national average and others with a TFR below the national average (see figure 1.2). The Western Zone has the highest TFR while the Eastern Zone has the lowest TFR.

Figure 1.2: Zone Total Fertility Rate



The data thus show an uneven distribution of CPR and TFR, despite the fact that everywhere across the country the same population policy applies and the same family planning programme is implemented. The Tanzanian family planning programme is believed to be well tested, containing clear procedures and guidelines. It was expected that the programme would have the same outcomes across the country after its implementation. There is, however, an unequal distribution of CPR across regions and LGAs in the country.

In order to gain a better understanding of causes of this unequal distribution, chapter 2 will review a number of studies done in Tanzania to show what is known about determinants of contraceptive use. This chapter will assess whether these studies explain the uneven distribution of the CPR and the fertility rates. Ahead of this discussion, it can already be established that the existing literature and the traditional tools of demographic enquiry cannot fully explain differences in CPR across Tanzania.

Therefore, in this research project another venue towards a solution was tried. Instead of taking the (potential) users of contraceptives as a focus of study, the provision of family planning services and contraceptives is used as the core object of research. The assumption is that differences at the supply side of the family planning may well contribute to differences in demand and consumption. The supply side in this case is a conglomerate of government agencies and NGOs that together implement a national family planning programme. The central research question for this study then is: How is Tanzania's national family planning programme implemented, and can differences in implementation practices explain differences in CPR across regions and LGAs?

1.3 Organisation of the book

This book is divided into ten chapters. The present introductory chapter is followed by the review of the empirical literature in chapter 2. The conclusion of that chapter will be that it is relevant to study the implementation of the government's family planning policy and the implementation of the contraceptive distribution programme in particular. In chapter 3, a model of policy/programme implementation is developed. The model's purpose is to guide the research into the quality of programme implementation in different regions and Local Government Authorities (LGAs) of Tanzania. Chapter 4 discusses the methodological approach for programme documents analysis and for the study of implementation. Chapter 5 presents the results of the analysis of policies governing the family planning programme at the national level. The purpose of the analysis is to reveal how family planning issues are addressed in the National Population Policy and in the National Family Planning Costed Implementation Plan (NFPCIP). Chapter 6 presents the research findings on the implementation of the family planning policies at the central government level. Chapter 7 does the same concerning programme implementation at the local authorities, and chapter 8 examines the programme implementation at the health facilities. Finally, chapter 9 contains the research results about clients' responsiveness. Chapter 10, the final chapter, wraps up the research findings in a comprehensive analysis aimed at answering the research questions.

Chapter 2

Determinants of Contraceptive Prevalance Rates

2.1 Introduction

Historically, Tanzania is one of the Sub Saharan countries that for a long time had policies and programmes that were intended to regulate population growth. In 1959, it was one of the first countries to introduce family planning services, under the Family Planning Association of Tanzania (UMATI) (Richey 2004). However, it was one of the last countries in Africa to prepare a comprehensive national population policy in 1992 (Richey 1999). It is argued that having a population policy is an indication to the international community that the government recognises it has a population 'problem' (overpopulation) and struggles to address it through family planning programmes (Barrett 1999).

The late president of Tanzania Julius K. Nyerere in 1882 (Kinemo 1995) alerted the nation with his speech, stating that;

> *'Women in Tanzania are the greatest workers. One cannot expect these people to give birth every year. unless Tanzanians are careful, our daughters will be giving birth every year like rabbits.'*

The speech was intended to encourage child spacing. Later, in 1989, the World Bank report described Tanzania as facing a serious population problem: rapid population growth that did not correspond with economic growth. The World Bank suggested the solution be the use of contraceptives. Various international organisations with differing goals showed an interest in supporting Tanzania simultaneously on this issue (World Bank 1989). The year of 1992 saw both the development of the National Family Planning programme followed by the National Population Policy (Richey 2004).

As pointed out in chapter one, there is an unequal distribution of CPR and TFR across regions and LGAs in Tanzania. Therefore, the brunt of this chapter is dedicated to investigating whether this difference can be explained using the existing literature. This chapter will analyse the published studies on family planning in Tanzania from 1970 to 2012 to identify determinants of CPR.

The search strategy to access the published articles and reports on family planning in Tanzania was conducted using the keyword 'Tanzania' in combi-

nation with the following substantives; 'family planning', 'fertility control', 'child spacing', 'contraceptive use' and 'contraception'. Family planning, fertility control and child spacing are usually synonymously used (Olaitan 2011) and contraception is the major components of family planning (Grizzle 2012). This was supplemented by adding other keywords from various types/categories of family planning methods such as 'traditional methods', 'natural methods', 'modern methods', 'temporary methods', 'permanent methods', 'pills', 'intra-uterine device (IUDs)' and 'Injection (Depo-Provera)'. Furthermore, the terms 'female sterilisation', 'vasectomy', 'adolescent pregnancy' and 'unwanted pregnancy' in combination with Tanzania were also used. The review was limited to the English-language and focused on literature published from 1972 to 2012 on family planning in Tanzania. The final search was undertaken in December 2012. The databases accessed were PiCarta, Purple search and Scopus.

One might consider this review to be biased because it only examined papers that were published in English while Tanzania is a Swahili speaking country. However, the studies accessed reflect what has transpired in Tanzania in relation to research on family planning. The fact that all articles were published in peer reviewed international journals is a guarantee that the studies and reports accessed were of high quality and in accordance with the principles of good research.

2.2 Accessed studies

A total of 100 titles and abstracts of studies were reviewed, starting from 1972 to 2012 *(for a list of accessed studies see appendix 1)*. Twelve articles focused on sexual behaviour and condom use in relation to HIV/AIDS and sexually transmitted infections (STIs/STDs). The remaining eighty-eight studies addressed family planning concepts. Lastly, forty-five articles and reports (51.1%) of listed titles starting from 2000 to 2012 were downloaded for thorough analysis.

Table 2.1: Number of titles accessed from 1972-2012

Years	Frequency	Percentage
1972-1976	2	2
1977-1981	4	4
1987-1991	7	7
1992-1996	22	22
1997-2001	22	22
2002-2006	21	21
2007-2012	22	22
Total	100	100

Table 2.1 shows a remarkable increase of research from 1992 onwards with an average of 22 investigations in every five years. This increase may be explained by the fact that in the 1990s Tanzania has undergone different reforms in all sectors; the launching of the family planning programme in 1989, the enactment of the National Health Policy in 1990 and the National Population Policy 1992, to mention a few. Moreover, in 1991-1992 the first Tanzania Demographic and Health Survey (DHS) was conducted. This became a rich source for secondary data analysis covering the whole country. Having new policies/programme and dataset from DHS attracted more researchers to explore different areas in health systems in Tanzania, including family planning programmes with aim of improving the services by looking on strength and area of improvements through research.

2.3 Focus of the studies

Most of the studies focused on determinants of contraceptive use. Those determinants range from barriers to use the contraceptives, resistance to adopt modern contraceptives, contributing factors for contraceptive use or discontinuation, contraceptive use for women engaging in other programmes such as pulmonary tuberculosis treatment, maternal and child health services and post abortion complications treatment. Some studies assessed the policies that aim to reducte of fertility rates and increase contraceptive use, whilst others explore the refugees' family planning profile, as well as efficiency of multimedia advocacy on family planning. Distribution/supply of contraception; community attitudes and perception towards family planning programmes; and training of different stakeholders on family planning were other areas addressed by the researcher. Generally, the main focus of the researcher is on individual perceptions leading to behavioural changes towards contraceptive use.

Clients' perception of the quality and accessibility of family planning services was another theme that often appeared. Another area of research involved measuring clients' satisfaction and quality of services by comparing private and public health facilities. Skills of health workers; quality of care and accessibility of health facilities; community and women's perceptions of the quality of family planning services were another area encompassed. Most of these studies were addressing the individual perception on the quality of services delivered in health facilities and perceived access in terms of time taken from household to health facilities and perceived distance.

Male involvement was another area that appears in some of the articles. It focused on analysis of male involvement in post abortion contraceptive use, reproductive health advocacy, determinants of male fertility and sexual be-

haviour. In addition, it analysed factors that hindered male involvement in different family planning services.

It has been observed in recent years that there have been some changes in the focus of the research, a shift away from family planning programming (contraceptive use in particular) and individual behaviour. The reviewed studies start converging on policy implementation in relation to contraceptive use. Among eighty-eight studies reviewed, four were focusing on policy issues. The first one was written by Chitama et al. (2011). The title of their paper is '*From papers to practices: district level priority setting processes and criteria for family planning, maternal, new-born and child health interventions in Tanzania'*. The study was analysing how LGAs sets the priority (planning process) for Family Planning, Maternal, Newborn and Child Health (FMNCH) to be included in Comprehensive Council Health Plan (CCHP). Three districts from Mwanza region were randomly included in the study. The study findings indicate that the District Reproductive and Child Health coordinators (DRCHco) were not engaged in the Council Health Planning Teams (CHPT). Moreover, the planning processes were 'ad hoc and implicit, the use of incomplete and inaccurate FMNCH information during prioritisation'. Low planning skills and deficient knowledge on FMNCH priority setting among team members and a lack of bargaining power of the team were pinpointed as other factors that hindering inclusion of the FMNCH in CCHP. The study repudiates the assumption that 'once the policy is adopted by the government will be implemented and achieved the desired outcome' (Chitama 2011).

The three others documents were written by Richey (1999, 2008). The first one *'Population politics and development: from the policies to the clinics'* was a book published in 2008, the other two documents were papers. The book was examining discourses and implementation practices of the population policy that transpired between the United Nations Fund for Population (UNFPA) and the health workers who implemented the policy activities.

The second document '*Global knowledge/local bodies: Family planning service providers' interpretations of contraceptive knowledge(s)'* examined the health workers' perceptions on contraceptives and to whether does this perception affects the dissemination of population knowledge. The study identifies the greater gap between the health workers and clients' knowledge and perception concerning contraceptive use. This create two cluster, women who are 'modern' by using the contraceptive and other been 'tradition' if they are not using the contraceptive. The clients who were educated were more advantages since they can discuss with provider about the contraceptive compared with non-educated who were ashamed to talk open since they might be seen they are 'traditional'.

The third article, '*Family planning and the politics of population in Tanzania: International to local discourse',* was exploring how the Tanzanian policy maker, implementer and end user (clients) view population growth. The study showed that the Tanzanian policy makers had as their goal the improvement of the '*quality of life of the people'* which is reflected in the ambiguity of the National Population Policy (1992). Likewise, the focus of the donors was to decrease the fertility rate by reduction of population through the use of contraceptives.

The Richey studies focused on the existing differences between the international donors who support the family planning programme and the local programme implementers. She identified a mismatch between the two groups. While the international donors viewed Tanzania as having an overpopulation problem that should be addressed through use of contraceptives, the Tanzanian policy makers saw the country as having developments problem that should be addressed by improving the population quality. This ambiguity is reflected in the National Population Policy (1992) which causes the policy to lack the focus on the way it can improve the quality of the population. This affects the family planning programme positively and became donor driven which is the ideology shared among policy maker, health workers and clients.

Lastly, a few articles dealt with the financing of reproductive health, service provider perception of contraceptives, analysis of demographic and health surveys and women empowerment. Moreover, the studies examined interpersonal relations, provided analyses of demographic and health surveys as well as surveys on women empowerment and fertility decline.

2.4 Determinants of the uneven distribution of contraceptive prevalence rate

The accessed literature as a whole presents a somewhat confusing picture. There were no studies among the reviewed papers that examine factors that might explain the uneven distribution of the CPR and TFR across the country. The reviewed studies focus on individual determinants of contraceptive use and of individual choice. Some studies mention two determinants, other three or more. The literature is not consistent and does not present one overall picture. Still, the most likely variables pinpointed by most studies to explain the individual behaviour concerning contraceptive use are the shortage of contraceptives in many areas, the limited number of qualified health workers, the quality of family planning services provided and the inaccessibility of health facilities in certain geographic locations. Socioeconomic factors and cultural values that maintain the demand for a large family and a lack of information concerning family planning services are highlighted too. Moreover, the use of contraceptives is influenced by women's knowledge of the

methods available, their religious affiliation, their wealth, and their ability to make decisions about contraceptive use. Other factors include male involvement in decision-making regarding contraceptive use, fear of side effects, place of residence (urban versus rural), and education level.

Indeed, there are strong indications that differences in contraceptive use can to some extent be explained by differences in education, religion and socio-economic status (Schanke and Lange 2008). For instance, Moshi DC in the Kilimanjaro region is the LGA with the highest CPR. It also happens to be an area with a high level of education. The Mara region on the other hand is the area with the lowest CPR while its level of education is generally low as well.

The studies that identified these and similar determinants were either analysing the country as a single unit or analysing a specific area (region or LGA). There are no comparative studies that analyse more than two regions or LGAs to determine the variables that explain the uneven distribution of CPR.

To fill this gap, we conducted research that applied a multilevel analysis of the available data on contraceptive prevalence rates across the country.[1] The results of this paper are summarised in the next section.

2.5 Individual and regional determinants of contraceptive prevalence

2.5.1 General

As argued in the previous section, existing studies fail to address the effects of regional differences on decision-making regarding contraceptive use. In this study, a multilevel analysis was done by aggregating variables on an individual level such as 'place of residence', 'religion', 'women's education' and 'household wealth' to the regional level. This enabled us to ascertain whether the regional variation in these variables can explain the uneven distribution of CPR. The aim was to answer two key questions: (1) what are the individual and regional determinants of contraceptive use; and (2) to what

1. Mackfallen G. Anasel[*, ***], Hinke Haisma[**] & Eva Kibele [**, ****] 'Variation in contraceptive prevalence rates in Tanzania: a multilevel analysis of individual and regional determinants'; Forthcoming.
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extent do these determinants explain regional differences in contraceptive use?

2.5.2 Data used

The Tanzania Demographic and Health Survey (TDHS) 2010 was used for this analysis. The survey collected information on the use and awareness of family planning methods, parity, marriage and sexual activity (NBS 2011). The analysis was based on the TDHS couples' file, which provides information on 1,148 women aged 15-49 years and their husbands. Regional variables were derived from the individual woman's file, which contains information on 10,139 women aged 15-49 years.

The factors describing the demographic and socioeconomic conditions in the Tanzanian regions were obtained by aggregating the individual-level variables: 'place of residence', 'religion', 'women's education' and 'household wealth'. These variables represent the proportion of women who live in rural areas; the proportion of women who are Muslim; proportion of women who are Roman Catholic, proportion of women who are Protestant; proportion of women who were poor or rich; and proportion of women who had no education or secondary education and above.

A multilevel logit regression model with contraceptive use as the outcome variable (use versus non-use) was fitted to determine individual and regional-level factors related to contraceptive use.

2.5.3 Individual and regional determinants of contraceptive use

Can different in contraceptive use from region to region be explained by aggregated individual variables? At the individual level the findings suggest that contraceptive use increases with household wealth, and with an increasing number of children ever born (this is the minimal way of using family planning to limit the number of children). The results further indicate that women who live in urban areas, and who got the contraceptive message from Community Based Distribution (CBD) and health workers, are more likely than other women to use contraceptives.

Some of the regional variability was explained by adding education as a regional-level variable: decreases from 0.748 to 0.560. However, a significant portion[2] of regional variation in contraceptive use still remains unexplained, even when both individual and regional-level variables were included in the multilevel model. It is nonetheless clear that the proportion of women with secondary education and above correlates with contraceptive use.[3]

2. The expectation was to decreases the variances from 0.748 to the value that approaches zero after adding the region variable.
3. For more information see appendix 2 and 3.

2.6 Conclusion

There is no conclusive answer yet to the question: what explains the variation in CPR and fertility rate from region to region in Tanzania. The existing literature suggests a number of variables that contribute to the explanation of contraceptives use. These factors range from demographic factors (education level, number of children ever born, and religion); economic factors (wealth); cultural factors; to family planning service related factors (availability of contraceptives, skills of service providers, quality of services provided and accessibility). Clients' knowledge, women's ability to make decisions about contraceptive use, fear of side effects, and place of residence seem to have positive association with individual decision to use contraceptives.

However, there was no study that explains the unequal distribution of CPR and TFR across the country. Even the multilevel study done by aggregating the individual variables to the regional level showed that there is still quite some unexplained variance in the distribution of the CPR over the regions and the LGAs. The traditional tools of demographic enquiry did not fully explain differences in CPR. Also, there is no study that reconstructs the actual implementation of family planning policies and programmes, starting from the national level to client level.

For this reason, the main objective of current study is to analyse the role of the family planning programme implementation process in explaining the observed geographical differences in CPR. Thus, family planning policy/programme documents analysis was done to gain an understanding of the core content of the policy and the programme as conceived and put into language by the actor of that policy and programme. On the basis of this reconstruction, research was done to establish whether variation in the quality of the implementation chain (from the central government level all the way to the individual health facility) could contribute to an explanation of the variation in CPR. The next chapter will develop a model for such a top down implementation chain.

Chapter 3

Modelling policy and programme implementation

3.1 Introduction

As discussed extensively in the previous chapter, most of the studies on family planning (Susan 2003; Ayoub 2004; Keele, et al. 2005; Anna 2006; Darroch 2008; Msofe et al. 2009; Schuter et al. 2009; Mohamed 2010; L'Engle et al. 2013) focus on individual determinants of CPR, examining family planning from the point of individual behaviour. These studies fail to consider institutional determinants of CPR. Moreover, the role-played by the policy/programme implementation process, particularly the extent to which policy/programme implementation process contributes to regional or Local Government Authority (LGA) differences in CPR has not been adequately researched (Lee 1998, Chitama et al. 2011). Examining the programme implementation process might be of importance in explaining why a particular programme does not meet the desired outcomes. Therefore, the main objective of this chapter is to model the policy/programme implementation process.

The purpose of the model is to guide a study to explore to which extent the differences in CPR can be attributed to variations in programme implementation. In some other fields, studies about implementation showed different orientations. For instance, the systematic literature review on programme implementation done by Dane and Schneider, (1998) found that 39 (24%) of 162 studies on mental health prevention which were conducted between 1980 and 1994 mainly described the steps that were taken to implement the programme document. Of the 39 studies, 13 assessed the relationship between programme implementation and programme outcomes. Moreover, Durlak (1997) reviewed 1,200 prevention studies conducted by the end of 1995 in mental and physical health. In the education sector, findings showed that 5% of the 1,200 studies provide data on the programme implementation process.

Dusenbury et al. (2003a) examined hundreds of outcome studies covering a 25-year period of drug prevention research; nine reports provide information on the relationship between implementation and outcomes. In addition, findings from 500 studies evaluated by Durlak and DuPre (2008) in five meta-analyses studies indicate that only 59 articles link between implementation process and outcomes.

3.2 Family planning methods

3.2.1 General

Before embarking on the modelling of programme implementation, the following sections will describe the contraceptive methods used in Tanzania. According to National Family Planning Procedure Manual (2012), the contraceptive methods are categorised into three major groups: short acting methods, long acting methods and permanent methods.

3.2.2 Short acting methods

Short acting methods include both contraceptives containing hormones and nonhormonal. The short acting hormonal methods are the most popular contraceptive methods and they are reversible - that is a woman can become pregnant again once she stops using the contraceptive. Different types of hormonal short acting contraceptive methods used in Tanzania are; (1) Combined Oral Contraceptives (COC): these are pills which contain low doses of two hormones, a progesterone and oestrogen. The hormonal methods are like the natural hormones progesterone and oestrogen in a woman's body. (2) The progestogen-only pill (POP): this contains only one hormone. (3) Emergency Contraceptive Pills (ECPs): used to prevent pregnancy following an unprotected act of sexual intercourse. (4) Depo-Provera, which is a three monthly injection that contains progestin only. The Depo-Provera is administered by intramuscular injection. The hormone is then released slowly into the bloodstream. Mechanism of action of Depo-Provera works primarily by preventing the release of eggs from the ovaries. Secondary mechanism: Depo-Provera thickens cervical mucus and prevents sperm from entering the uterus.

Non-hormonal contraceptive methods are the male condom, the female condom and natural methods. The male condom is a barrier device used during sexual intercourse to reduce the likelihood of pregnancy and spreading sexually transmitted infections (STIs). The female condom is made of polyurethane (a thin, transparent, soft plastic). It is a device that is used during sexual intercourse to prevent pregnancy and reduce the risk of sexually transmitted infections (STIs). Natural family planning methods include fertility awareness based methods, withdrawal and the lactational amenorrhea method. The basic idea of the fertility awareness based methods is to determine the fertile and infertile days of the menstrual cycle by self-observation. The lactational amenorrhea method is effective for six months after childbirth and can be used by amenorrhea women who are exclusively breastfeeding.

3.2.3 Long acting methods

The long acting methods are divided into two types: the implant and the Intra Uterine Contraceptive Device (IUCD). Implants are small flexible rods that release a progestin like the natural hormone progesterone in a woman's body. It is placed just under the skin of the upper arm. After being inserted, they provide pregnancy protection for up to 3 to 5 years, depending on the brand of implant. In Tanzania, two brands are used: Implanon that protects women for three years and Jadele that protects women for five years.

An IUCD is a small, flexible plastic T-shaped frame that is inserted into a woman's uterus to prevent pregnancy. Two types of IUCD are readily available. First the copper-bearing IUCD that provides protection from pregnancy for at least 12 years. Second, the hormonal IUCD steadily releases small amounts of levonorgestrel into the uterine cavity. It is marketed under the brand name Mirena and it provides protection from pregnancy for five years. In Tanzania the most common IUCD used is a copper bearing-device with copper bands or wire around the stem and arms. The hormonal IUCD is expensive and not readily available in Tanzania. Copper IUCDs work primarily by causing a chemical change in the uterus that damages sperm and ovum before they can meet, thus preventing fertilisation.

3.2.4 Permanent methods

The permanent family planning methods are commonly used by woman and man who will not want more children. It involves a surgical procedure which for the women in Tanzania is termed as minilaparotomy (in short minilap) with bilateral tubal ligation. It involves making a small incision in the abdomen. The fallopian tubes are brought to the incision to be tied and cut. This procedure sometimes is called female sterilisation, tubal sterilisation, tubectomy and bi-tubal ligation.

A similar procedure for men it is called vasectomy. Surgery is done to occlude and divide the vas difference (sperm duct) to create discontinuity in the vas deferens. Thus sperm cells produced in the tests will not be part of the semen/ejaculate that normally reach the egg and effect fertilisation.

3.2.5 Family planning programme

The government's family planning programme is intended to inform women and couples about all these methods so as to enable them to make an informed choice concerning the planning of childbirth. Furthermore, the family planning programme provides for distribution of contraceptive methods according to the informed choice of women and couples.

3.3 Programme implementation

3.3.1 General

Policy/programme implementation encompasses actions done by the government, private organisations, groups of peoples or individuals that are focussed at the achievement of goals set out prior policy/programme implementation. Most of researchers were paying more attention on policy/programme design and policy/programme evaluation. Less attention was paid to how policy/programme is put into effect until 1973 when Pressman and Wildavsky introduced the 'implementation theory' (Schofield 2001). This concept was further developed by other scholars, notably Van Meter and Van Horn (1975) who pioneered a top-down model of implementation with an emphasis on communication during implementation. Mazmanien and Sabatier (1983) further developed the top-down model by identifying 'tractability' variables that affect different stages of the policy/programme implementation process. Other scholars criticised the top-down approach and came up with another model that featured a bottom-up approach (Lipsky 1971; Smith 1973 and Hjern and Porter 1979).

3.3.2 Top-down

The top-down model was based on the assumption that implementation commences with policy/programme documents that stipulate the objectives and goals desired to be achieved, usually at a central level of government. Then the implementation process follows, usually at a local government level (Sabatier and Mazmanian 1979). Thus top-down scholars perceive policy/programme designing as a charge of the central government. It includes the stipulation of the activities that will be carried out by both the central government and local governments (Matland 1995). The main actors in the top-down model are the decision-makers who formulate the policy/programme documents that are believed to address the policy problem. The study of an implementation process will involve the reconstruction of predetermined objectives, goals and means. Such a reconstruction enables the researcher to establish whether the policy has been implemented as designed. Top-down theorists are interested in describing and explaining deviations from the stated policy during the implementation and to suggest remedies that will ensure policy compliance. Sabatier and Mazmanian (1979) for instance identified six conditions needed for effective implementation: 'clear objectives', an adequate 'causal theory' underlying the policy, 'a legal structure to enhance compliance', 'committed and skilful officials', 'support of interests groups' and 'changes in socio-economic conditions that do not undermine the political support or the causal theory' (Sabatier 1986). Other researchers emphasised that in order to achieve the policy goals, the poli-

cy/programme documents needed to stipulate clearly what should be done by whom, when and where.

3.3.3 Bottom-up

The scholars in this approach stress that policy/programme implementation involves two levels of government: (central level and local level) that are equally important. Implementation is assumed to take place in a multi-actor network. The research interest is to establish the transformation of policy during the phase of the implementation. In order to do so, the different actors who are involved in implementation are asked about their goals, their strategies and their planned activities to realise the stated goals (Hjern and Porter 1979). Often the analysis of policy/programme implementation starts with street-level bureaucrats (bottom) and ends up at the 'top' of policy and programme makers.

In this research, both approaches are applied. The top-down approach is deployed to reconstruct the family planning programme implementation starting from the ministry level all the way down to the (potential) users of contraceptives (the clients). The aim of this investigation is to ascertain whether the implementation process moves along as designed at all levels. The bottom-up approach will be used to assess the dynamics among street level bureaucrats at health facilities during the implementation of the programme in the health facilities. The aim is to determine if these street level bureaucrats apply coping strategies to deal with obstacles in the implementation.

The following sections will explain how these two approaches have been modelled to analyse the family planning programme implementation process.

3.4 Properties of programme implementation

3.4.1 General

There are a great variety of implementation studies to draw on for the present research. The programme to be implemented in this case has a few specific features: it is medically oriented, it is aimed at educating clients in family planning and the use of contraceptives and it is well tested in a wide variety of countries and circumstances. Therefore, this research took a lead from studies concerning similar promotion and prevention programmes (Durlak and DuPre 2008).

Previous studies (Durlak and DuPre 2008; Berkel et al. 2011) have identified eight properties of programme implementation namely; fidelity, exposure (dosage), quality of delivery, participant responsiveness, programme differentiation, monitoring and control, programme reach and adaptation. However, most of the research measures define fidelity of implementation as

a combination of five dimensions (Dane and Schneider, 1998; Domitrovich and Greenberg 2000; Mowbray et al. 2003; Dusenbury et al. 2003; Carroll et al. 2007; Durlak and DuPre 2008; Fagan et al. 2008). Durlak and DuPre (2008) and Berkel et al. (2011), define implementation fidelity as:

1. Strict *adherence* to methods or implementation protocol that conforms to theoretical guidelines,
2. The *dosage/exposure* as the quantity of programme implemented in relation to the amount agreed by the programme documents
3. The *quality of programme delivery*, that is the skills used by the programme implementer to transform the programme components from paper to an end user in this case the clients,
4. *Participant responsiveness*, i.e the degree to which participants are engaged with the programme and
5. *Programme differentiation*: are critical features that distinguish the programme are present or absent.

The sections below will discuss the eight properties of programme implementation, showing their relationship with outcomes from previous studies and how they were operationalised. The operational variables used in this modelling were selected from the literature and from the NFPCIP document (2010). Others were drawn from the Family Planning Procedure and Guidelines and National Family Planning Procedure Manual (2012). After review, the selected properties were operationalised in such a way that they fit the study on the implementation of the family planning programme.

3.4.2 Adherence

Dane and Schneider (1998) define programme *adherence* as 'the extent to which specified programme components were delivered as prescribed in programme manuals (documents)'. Attaining compliance in the implementation process increases the chances of programme success and can lead to higher benefits for programme participants (Durlak and DuPre 2008). A systematic review by Durlak and DuPre (2008) focusing on the factors that influence programme implementation indicates that 76% of the studies reported a significant relationship between the level of implementation *adherence* and programme outcomes. Most of the studies found that high levels of programme implementation as designed were associated with better outcomes. Implementation with lower *adherence* to the implementation protocols is often associated with poorer outcomes (Dane and Schneider 1998). *Adherence* indicators include 'compliance to programme content', 'compliance to methods of the programme' and 'compliance to prescribed activities'. Other items are: 'delivering of all core components of the programme to the appropriate population', 'training the staff appropriately', 'using the right

protocols, guidelines and implementation materials at the different levels'. *Adherence* data are usually reported as a proportion of programme components that were delivered in accordance with the programme documents.

Reviews of different family planning activities conducted by the Ministry of Health and Social Welfare (MoHSW), the regions and the LGAs will be applied to reveal the level of programme *adherence* with guidelines and manuals prepared by MoHSW. The review will: (1) establish if the training received by implementing actors concerning family planning programme in regions and LGAs uses the programme documents (2) assessing if the region and LGAs are using guidelines and manuals prepared and prescribed by the ministry (3) establish if the Comprehensive Council Health Plan (CCHP) and the implementation plan produced in the LGAs adhere to the ministerial guidelines and (4) establish whether the provider provides adhere to guidelines and standards during provision of family planning services.

The plan was to access the following documents: programme implementation plan in all levels starting from MoHSW, regions, LGAs, and at health facilities; CCHP, reports sent to higher authority and other received documents. We assumed that each level should have a set of documents guiding the implementation. The intention was to determine whether the implementation plan prepared with regions, LGAs and health facilities adheres to the ministry guidelines and manuals.

At the beginning of this study, interviews were conducted with key informants: two regional health secretaries and three LGA health secretaries. The aim was to identify the types of documents produced by the LGAs and the regions to support the implementation of the family planning programme. It was found that the regions and LGAs did not prepare their own programme implementation plans. Instead, they prepared the CCHP that incorporated all LGA health plans. In that respect the review has been confined to CCHP documents.

3.4.3 Programme exposure (dosage)

Programme *exposure* (also referred to as dosage) is the amount of programme delivered in relation to the amount prescribed by the programme document. A review done by Durlak and DuPre (2008) shows that out of the 59 studies explaining the relationship between implementation and outcomes, 29 address *exposure* and show a positive relationship (Aber et al. 1998; August et al. 2003a; August et al. 2003b; Bell et al. 2005; Komro et al. 2006; Saunders et al. 2006). Indicators used to measure exposure include: the 'number of sessions or contacts', 'the frequency and duration of sessions', 'number of educational materials provided to participants' and 'duration of time spent at each session'. Methods for measuring *exposure* include: the analysis of the documentation on session attendance and interviewing the

implementers on the activity conducted (Hill et al. 2007; Sloboda et al. 2009; Hall et al. 2012).

In this study, 'exposure' and 'dosage' are used interchangeably. The dosage was operationalised as; (1) number of programme documents produced (2) the number of supervision sessions (3) number of orders and orders processed of family planning drugs and other related supplies, (4) number of outreach activities (community advocacy) done, (5) number of trainings attended/conducted including on job training and (6) number of available workers trained on family planning service provisions as a parameter to determine the level of programme *exposure* in all study regions and LGAs cases. A detailed explanation on how they were operationalised is given in chapter 4. By applying these indicators, it is possible to ascertain the level of dosage delivered in the respective LGAs and make a comparison between the LGAs.

3.4.4 Quality of delivery

Quality of delivery reflects the way programme implementers convey programme commodities and services to clients (Dusenbury et al. 2003), including implementers' use of clinical process skills (Dane and Schneider 1998; Forgatch et al. 2005; Durlak and DuPre 2008). Previous studies showed for instance, that the *quality of services delivery* had a positive association with decreases in adolescent substance use (alcohol and drugs) and their consequential problems (Hansen et al. 1991; Kam et al. 2003). The tendency of implementers to use the skills and techniques or methods prescribed by the programme guidelines and manuals signify the *quality of services delivered*. This is demonstrated through provider preparedness, enthusiasm, respectfulness, confidence, and by the ability to respond to questions and communicate clearly. The quality of delivery may act as a moderator between an intervention and observed outcomes. For example, if 100% of a programme's material is covered but delivered poorly, positive participant outcomes may not be realised.

In this study, 'quality of delivery' will be split into two sub-variables: firstly client care and interpersonal relations and secondly counselling and education. These concepts have been adopted from the MoHSW and the Tanzania Bureau of Statistics (NBS). The Service Provision Assessment Survey identifies three aspects of 'quality of family planning provision': 'interpersonal relation', 'counselling and education' and 'clinical observation' (URT 2007; Hutchinson, et al. 2011). The research chooses to use the first two aspects and leave out the clinical procedure observation. A detailed explanation on how they were operationalised is given in chapter 4.

3.4.5 Participant responsiveness

Participant responsiveness refers to the manner in which participants react to or engage in a programme. Previous research on prevention operationalised participants' responsiveness as 'the participants' level of interest in the programme', 'the participants' perceptions and attitudes about the relevance and usefulness of a programme', level of engagement, enthusiasm, satisfactions with the services and 'acceptance of the services provided in the programme (Spoth et al. 2002). Studies showed that participant satisfaction, the percentage of home practice assignments completed and participants' responsiveness to the programme are associated with programme outcomes (Nye et al. 1995; Blake et al. 2001; Tolan et al. 2002; Baydar et al. 2003; Garvey et al. 2006; Prado et al. 2006).

Participants' responsiveness was operationalised through examining the level of acceptance; awareness of different methods and their usage; and satisfaction with services received from providers. One of the determinants of the clients' continuation in utilizing the services offered by the programme (i.e family planning) is satisfaction with those services (Berkel et al. 2011). The information gathered from selected variables might be linked with the one collected from *quality of delivery* so as to get a clear picture of what was observed by the researcher together with the clients' perception and experiences about a programme. A detailed explanation on how they were operationalised is given in chapter 4.

3.4.6 Programme differentiation

This is the degree to which the critical components of a programme are distinguishable from one another and from other programmes. It can also refer to the process of identifying the critical components of a programme that are essential for producing positive outcomes (Dusenbury et al. 2003). From the definition, we may notice that *programme differentiation* does not measure quality of the implementation process; rather it is a part of the evaluation of the programme intended to reveal whether the critical components that distinguish the programme activities from other programmes are present or absent (Century et al. 2010). This dimension was not addressed in this study (explanations are highlighted in the last section).

3.4.7 Monitoring and control

This dimension involves describing the nature and amount of services received by the participants. *Monitoring and control* helps to assess the progress of the programme and act accordingly if there is any problem associated with implementation. None of the reviewed studies indicated to address *monitoring and control*.

In this work, *monitoring and control* was measured through assessing the supervision process done by the central government (that is: the Ministry of Health and Social Welfare) and by the regions concerning LGA activities. The assessment will describe the nature of the supervision process and the number of supervisions done with regard to requirement of guidelines and procedures. The same observation will be done for LGAs in their relation with health facilities.

3.4.8 Programme reach

Programme reach envisages the extent to which criteria or goals that were determined prior to the programme implementation have been achieved. This includes the percentages of participants being served as the representative of the programme target group. Very few studies have analysed the programme reach in implementation process and its relationship with the outcomes (Hopper et al. 1996; Lalongo et al. 1999). The two studies conducted show weak relationship with outcomes (Durlak and Duper 2008). *Programme reach* was examined by assessing the amount of the programme that has been delivered in the regions and LGAs studied in relation to targets stated. A detailed explanation on how they were operationalised is given in chapter 4.

3.4.9 Adaption

Adaptation refers to the changes made during programme implementation in the form of additions or modifications of the content and process of programme delivery as prescribed by the programme document (Durlak and DuPre 2008). This process has been termed by some researchers as 'lack of adherence' (Elliott 2004) while other researchers have defined it as additions to the programme to fit the context of the implementation (McGraw et al. 1996; Berkel et al. 2011). *Adaption* was operationalised by looking what new intervention or quantity the implementer introduces in their area different from the original programme. During family planning programme implementation in the regions, LGAs and health facilities, there might be certain practices that differ from what is stipulated in the original programme documents (national family planning programme documents) that reflect *adaptation*.

In summary, the four dimensions (adherence, exposure, quality and participant responsiveness) are believed to occur within the place of services delivery (Berkel et al. 2011). The programme managers and implementers control *adherence, exposure* and *quality of services* delivered whereas *participant responsiveness* is the property of participants. The *programme reach* is the extent to which targets defined by the ministry, the regions and LGAs are indeed attained at a specified period of time. This property has a direct relation with the target group.

For the purposes of this study, *implementation fidelity* will refer to three properties: *adherence, exposure/dosage* and *quality of services delivery.* The three properties selected are implementation fidelity in its real sense. The *participant/clients responsiveness* is the effect of the programme implementation. *Adaption* is a conscious breach of fidelity with the intention to be more effective i.e more fidelity concerning the goals of the programme. It is a divergence from protocols in order to realise programme goals. *Monitoring and control* is an additional feature to enhance implementation fidelity. *Adherence, exposure/dosage* and *quality of services delivery* are the effects and *monitoring and control,* and *adaptation* are conditions that influence fidelity. *Programme reach* is an output of the implementation fidelity.

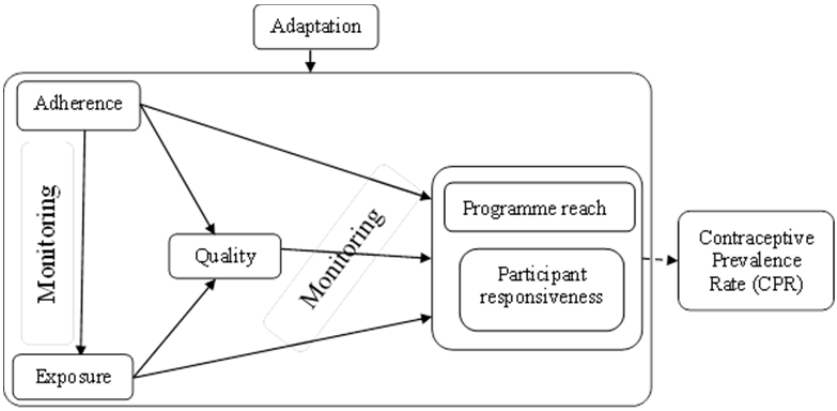
Therefore, this review results in a model containing seven properties that appear suitable for the examination of the family planning programme implementation in the regions, the LGAs and the health facilities. The selected properties are *adherence, exposure/dosage, quality of delivery, adaptation, participant responsiveness, programme reach, and monitoring and control.*

Programme differentiation was not examined since it does not apply. In the implementation programme under scrutiny, the implementers cannot differentiate and choose between different programme components. The focus of this study is to examine the implementation process and describe the possible programme related properties that explain uneven distribution of CPR across regions and LGAs.

3.5 Programme implementation impact model

With the aid of the diagrams, the causal linkage of the seven properties of programme implementation were displayed in the model. The aim is to show the hypothetical relations between these properties. As shown in figure 3.1, CPR is thought of as the outcome of the whole implementation process. *Participant responsiveness* and *programme reach* are implementation process outputs. The *programme reach* is explained by the *quality of services* provided, *dosage* delivered and the extent implementer *adhere* to original plan. *Adherence* with the programme plan has effects on the outputs as well. *Adherence* affects the *exposure* and *quality* of the programme delivered that all together effects *participant responsiveness* to programme either accepts or rejects the programme. The *adaptation* affects all properties either positively or negatively. Lastly, the *monitoring and control* is hypothetically done at all stages of programme implementation to see whether the programme is implemented as designed and whether it achieves the desired outputs.

Figure 3.1: *Conceptual model*



3.6 Programme implementation process flow

In Tanzania, policies and programmes are formulated by the central government. After formulation, they are sent to the implementing LGAs in the form of programme documents, guidelines, manuals or as directives (figure 3.2). The MoHSW and regions form part of central government. The ministry is responsible for policy/programme formulation, whereas regional offices are responsible for resource mobilisation, interpretation of policies and translation of programmes into actions. In addition, it provides technical support to the LGA, supportive supervision and inspection of LGA health services provision. The LGAs are responsible for the implementation of policies and programmes through preparation of Comprehensive Council Health Plans (CCHP) and regular reporting on its implementation progress (URT 2007[1]). LGAs receive the action programme from the regional office or directly from the ministry as input for programme implementation. Hence, the LGAs prepare the plans for programme implementation and implement the programme simultaneously.

1. National Health Policy 2007.

Figure 3.2: Programme implementation process flow

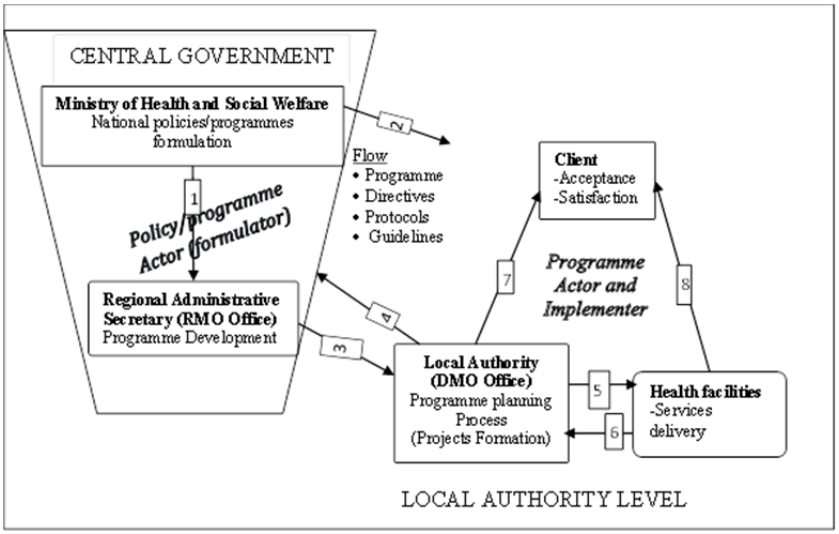


Figure 3.2 has different arrows showing the flow of programme documents and directives from one level to another. Arrow 1 shows the flow of programme documents from ministry to the regional administrative secretary (RMO's office). The RMO's office is responsible for programmes development that will be implemented in different LGAs within the region. However, the LGAs may also receive programme, manuals, guidelines documents and directives directly from the ministry (arrow 2). On return, LGAs submit implementation report(s) and other information requested by either the region or the ministry (arrow 4). According to the National Health Policy (URT, 2007) the regional level is responsible for the interpretation of policy and for the translation of programmes into actions. So we expect to have a flow of guidelines, manuals and directives from the regional reproductive and child health department to the LGAs (arrow 3).

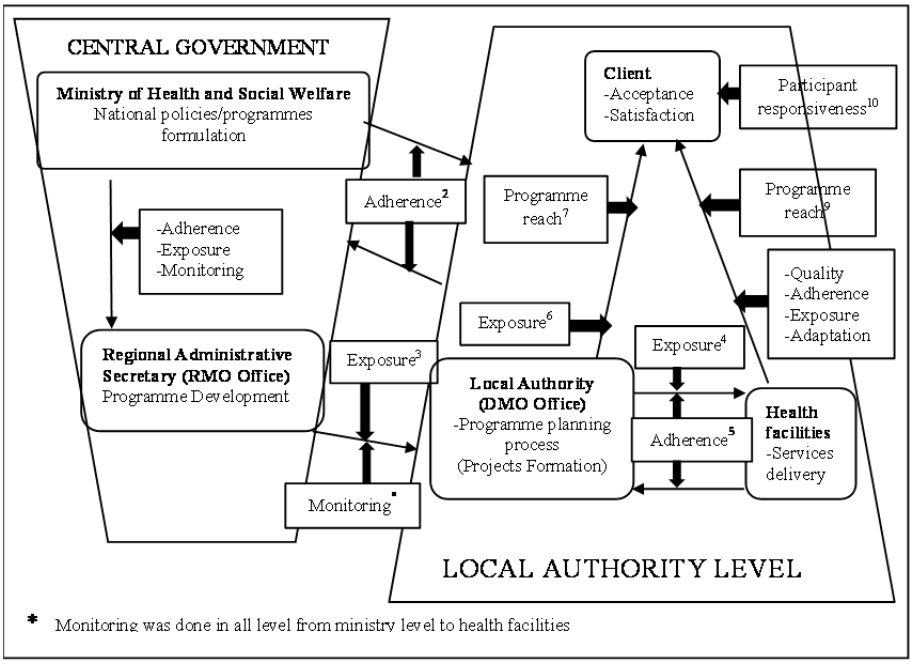
At the LGA level, the Local government authority Health Administration (DMO's office) has the role of providing health services at level one, including the local government authority hospitals; private/faith based hospitals; and health centers and dispensaries (URT 2007). The local government authority Reproductive and Child Health section under the DMO's office formulates the action plan for the programme implementation at the local government authority. Also this section implements the formulated projects at health facilities, informs of guidelines, manuals and directives (arrow 5). Furthermore, it conducts programme advocacy and sensitisation to the community (arrow 7). In return, the health facilities submit implementation reports to the health department (reproductive and child health section) (arrow 6). At health facilities, the programme is transformed from paper to action

(actual implementation process). Thus, it is at the health facility level where the services stipulated in the guidelines, manuals and directive received from the LGA level are delivered to clients (arrow 8); either as stipulated or with some changes to accommodate any contextual differences.

3.6.1 Operational model

The operational model is designed with an aim to visualise how an organisation delivers the programme components to the beneficiaries. Figure 3.3 presents an interrelationship, again with the help of symbols, of the programme impact model and implementation process flow. The rounded rectangle shows the programme actors, rectangles symbolise the study concepts that are to be analysed at different levels and arrows depict the implementers. Programme *adherence* was examined in four areas; the documents shared between ministry and regional administrative secretariat; ministry and local authorities; DMO's office and health facilities and health facilities and clients. Programme *exposure/dosage* was measured in four areas as well; between RMO's office and DMO's office; DMO's office and health facilities; health facility and clients; and DMO's office and the community.

Figure 3.3: Operationalisation model



The *monitoring and control* was observed in three administrative relationships; between the ministerial level and the regional level; between the regional level and the LGA level; and between the LGA level (DMO's office) and the health facilities. *Programme reach* was measured in two relationships, (from DMO's office to clients and from health facilities to clients) to assess the amount of services and commodities offered to clients. The *quality of services* was examined by observing the procedure employed by the health providers at health facilities. Lastly, *participants' responsiveness* was assessed through an exit interview which was administered to clients of family planning services at the health facility level.

3.6.2 Sub research questions derived from the operational model

The main objective of this chapter was to model the policy/programme implementation process. To be able to study the family planning programme implementation process, four specific research questions were developed. The formulation of these research questions was guided by the operational model discussed in figure 3.3.

1. *How does the central government implement the family planning programme?*

The purpose of this question is to describe the implementation process of family planning programme at the central government. The proposition is that if the central government delivers the programme components equally in all LGAs, they would have the same level of CPR.

2. *How do the local government authority programme managers deliver the programme components in their areas?*

This question will guide the reconstruction of family planning programme implementation at the LGAs. The reconstruction will focus on the plans, targets and strategies formulated by these LGAs to implement the programme in the health facilities. The proposition is that the LGA's level of *adherence* with national guidelines is to be reflected in the LGA planning. Subsequently, a high level of LGA *adherence* will correspond with a high *quality* of services provided, which in turn produce a high CPR. These propositions are based on the assumption, underlying the national policy, that the plans of the LGA's translate national policies and guidelines into locally applicable rules and protocols.

3. *How do the programme implementers (health providers) convey programme commodities and services to clients?*

The aim of this question is to describe how the street level bureaucrats (health workers) transform the policy and programme documents into actual services delivered to end users (clients). The assumption is that the better the

LGA plans its family planning activities, the higher the implementation fidelity in the facilities. The second proposition is that the higher the implementation fidelity, the higher the clients' responsiveness and CPR.

4. *What is the clients' responsiveness towards the family planning programme?*

The question seeks to establish the clients' responsiveness towards the health facility's family planning programme activities. It assumed that a positive reaction of the clients towards the programme is a prerequisite for the programme to realise its targets. The proposition is that a certain level of clients' responsiveness would correspond with a certain level of CPR.

The purpose of these questions, therefore, is to provide step-by-step parts of the answer to the broader question of this study. In the end it will be possible to determine whether differences in family planning programme implementation practices explain regional and LGA differences in CPR. The study is intended to answer one central research question: what roles do the family planning programme implementation process play, in explaining regional and LGAs' differences in CPR?

3.7 Concluding remarks for the chapter

In summary, in this chapter the approaches and models were presented that will be used to investigate policy/programme implementation. From the literature, seven properties of programme implementation were derived, namely *adherence*, *exposure/dosage*, *quality of delivery*, *participant responsiveness*, *programme reach*, *adaptation* and *monitoring and control*. Previous studies on implementation have been largely limited to one property and lack attention to combining more than one property at once (Berkel et al. 2011). The seven properties operationalised in this chapter are incorporated in one model that was used to reconstruct the family planning programme implementation process from the ministerial level to the end user (clients). The critical first step done in this chapter was to identify the properties that determine the programme implementation from the literature and to operationalise them. The next chapter explains the methodological approaches that accommodate all the properties identified.

Chapter 4

Methodological approaches for studying programme implementation

4.1 Introduction

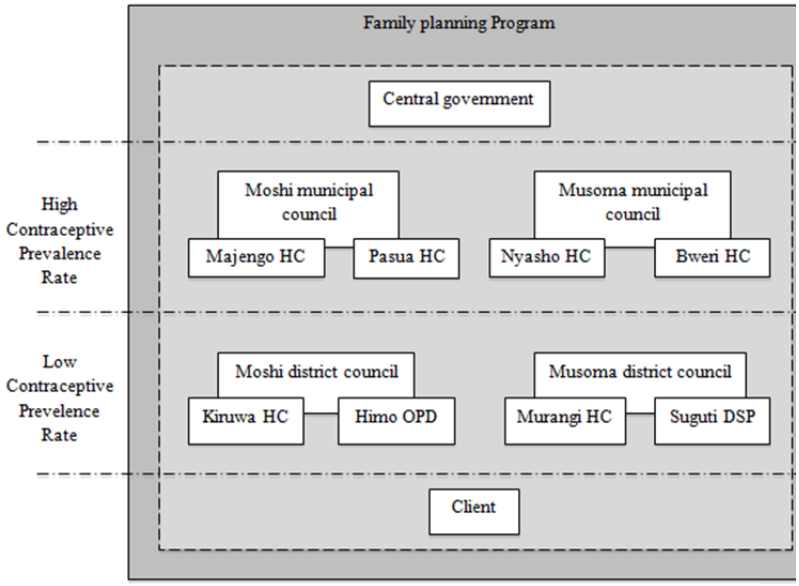
The purpose of this study is to measure the properties of programme implementation to ascertain whether differences in implementation practices explain the geographical differences in CPR. Different methods have been proposed for measuring policy/programme properties. These include observation, post-implementation surveys amongst programme implementers and interviewing implementers (Resnicow et al. 1998; Hill et al. 2007). Some researchers suggest that observation and interview are the most reliable methods. This study uses documentary review, interview and observation as key methods to examine the implementation of family planning programmes in Tanzania. Despite the fact that some scholars such as Resnicow et al. (1998) and Goldberg et al. (2004) suggest that observation and interview methods have limitations especially in large-scale programmes, this chapter aims to show how the two can be used successfully.

The chapter explains the data collection process and analysis strategies used. The first three sections describe the unit of analysis, the choice of the level of health facility suitable for the study and the selection of respondents. It is followed by a section describing the methodology for the qualitative approach. It outlines the three methods of data collection used (documentary review, in-depth interview and client-exit interview) and it describes the analysis of the qualitative data obtained by these methods. The chapter then details the methodological tools used for the collection and analysis of quantitative data, that is the observation checklist, the data collection process and the data analysis strategy. The chapter is finished off with a discussion on the pilot study and its consequences for the rest of the data collection tools and how the issues of access and privacy have been taken care off.

4.2 Unit of analysis

The study deployed an embedded case study design (Yin 2003), whereby the family planning programme was used as a case study to examine the implementation process. Within this general case study, four embedded units of analysis were identified: the central government, local authorities, health facilities and clients (figure 4.1).

Figure 4.1: Embedded units of analysis of the family planning programme



The units of analysis in the study were the Ministry of Health and Social Welfare (MoHSW), Kilimanjaro region and Mara region. The field study was conducted from May 2014 to February 2015. In this study, the central government was represented by the department of reproductive and child health of the Ministry of Health and Social Welfare, and by the region with the highest CPR (i.e. Kilimanjaro) and the region with the lowest CPR (i.e. Mara). The two extremes in CPR were obtained from the Tanzania Demographic and Health Survey (TDHS) 2010. Moreover, four local authorities (two from each region) were studied. These LGA's were Moshi MC and Moshi DC from Kilimanjaro region and Musoma MC and Musoma DC from Mara region. These local authorities were selected based on the Regional Health Management Team (RHMT)'s annual operational plan of 2013 that showed the local authorities with highest and lowest CPR in each region. The Moshi MC and Musoma MC had the highest CPR from their respective region, while, the Moshi DC and Musoma DC have the lowest CPR rates from their respective region (see table 4.1 and 4.2).

At the level closest to the client, two health centers from each local authority were selected:

i. Moshi municipal council: Majengo and Pasua health centers;
ii. Moshi DC: Kiruwa Vunjo and Himo health centers;
iii. Musoma MC: Nyasho and Bweri health centers; and
iv. Musoma DC: Murangi health center and Suguti Dispensary.

All the health facilities included in the study were health *centers* except one (Suguti) which was a *dispensary*. The selection of the facilities was based on the following. Two of the four LGAs (Moshi MC and Musoma MC) had only two health centers each. That being the case, these health centers were purposefully included in the study. The Moshi DC had five health centers. Out of these five, two health centers were selected purposefully with the help of DRCHco. She identified a health centre in a remote area (Kiruwa Vunjo) and one in a township (Himo health center). Suguti dispensary was selected because Musoma DC had only one health center. This necessitated the addition of the dispensary to make up a total of two facilities. The last unit of analysis is the client. Clients were selected from each of the eight health facilities included in the study. A total of 115 clients were observed and a subsample of 24 clients were interviewed.

Table 4.1: Contraceptive prevalence in the Kilimanjaro region: child health indicator

Councils	**Year**		
	2010	2011	2012
Siha DC	30.1	11	11
Hai DC	50	31.3	18
Moshi DC	9	11	11
Mwanga DC	7.1	10.6	15.3
Rombo DC	13	14	10
Same DC	8	13	15
Moshi MC	19.2	26	27.3

Source: Kilimanjaro annual operation plan for year 2013/2014

Table 4.2: Contraceptive prevalence rate in the Mara region

Councils	**Year**		
	2011	2012	2013
Bunda	50	17	26
Butiama	-	-	38
Musoma MC	67	36	75
Musoma DC	39	22	30
Rorya	51	19.4	24
Serengeti	42	40	36
Tarime DC	35	15.7	34

Source: Mara annual operation plan for year 2014/2015

4.3 Level of health facility suitable for this study

According to the National Health Policy (2007), health facilities in Tanzania are categorised into five levels, following the government administrative structure: (1) National/consultant hospital; (2) regional hospital; (3) district hospital; (4) health center and (5) dispensary.

4.3.1 The consultant hospital

This is the highest and the first level of hospital services in the country. Currently there are four national referral hospitals in the country, namely, the Muhimbili National Hospital which caters for the eastern zone; Kilimanjaro Christian Medical Centre (KCMC) for the northern zone; Bugando Hospital for the western zone; and Mbeya Hospital for the southern highlands.

4.3.2 The regional referral hospitals

This constitutes the second level of health facilities. Every region is required to have one hospital. The hospital is meant to serve one million inhabitants. The regional referral hospital offers similar services to those provided at district hospitals, though the former have specialists in various fields and offer more specialised services than the latter.

4.3.3 District hospitals

The third level according to the structure consists of the district hospitals. These hospitals are meant to serve a population ranging from 100,000-200,000. In an ideal situation, each LGA is supposed to have one public hospital. However, there are LGAs without a public hospital. In such situations, the government normally negotiates with non-governmental (often religious) organisations to designate a hospital as district hospital (formally called a 'District Designated Hospital' (DDH)) which operates at level three.

4.3.4 Health Centres

The fourth level of health facilities in Tanzania comprises of health centers. A health center has a catchment area of about 50,000 inhabitants and is usually headed by a Senior Medical Assistant who has a sufficient level of leadership skills. Health centers provide among other services preventive and curative services, reproductive and child health services and in-patient treatment with about 20 beds.

4.3.5 Dispensaries

The fifth formal level of health facilities is the dispensary. A dispensary is meant to serve a population of about 10,000. The roles of a dispensary are to provide curative, preventive, reproductive and child health services. In addition, dispensaries are the fundamental providers of delivery services particularly in the rural areas.

4.3.6 Rationale for the selection of health centre as the unit of analysis

The counselling on family planning and most of the short acting and long acting contraceptive methods are provided by the health centers (MHSW 2010). In other words, in these units the programme is transformed from the abstract paper form to concrete service form. Thus the health center was designated as the unit of analysis. Another rationale is that health centers are comparable across the four LGAs cases. District hospitals were not suitable for the following reasons: (1) some local authorities do not have a district hospital. Hence, uniformity of services lacks if compared with those LGAs with a district hospital. For instance in the present study, none of the four LGAs studied has a district hospital.Two of them, Moshi MC and Moshi DC, had a designated district hospital owned by the Roman Catholic Church. (2) Private hospitals designated as district hospitals, especially those owned by Roman Catholic organisations, do not allow the provision of family planning services. (3) District hospitals provide more specialised services, particularly surgery. Because of this speciality they mainly offer permanent contraceptive methods. In practice a client is required to obtain a referral from a lower levels (health center or dispensary).

4.4 Selection of respondents

The study used three kinds of informants to acquire data about the actual implementation of the family planning programme from the ministerial to the facility level. A multi-stage purposive sampling was done to select key informants from the central government, the local authorities and at the health facilities. The aim was to include all key actors who were directly involved in the family planning programme implementation process. The respondents included: the programme officer from the reproductive and child health section at the MoHSW; the Regional Reproductive and Child Health coordinators (RCHco); the Regional Health Secretaries; the District Reproductive and Child Health coordinators (DRCHco) and the Local government authority Health Secretaries; making a total of 13 participants. In addition, the eight (8) providers from eight health facilities providing the services at the family planning unit were included in the study as well.

For the observation, a form of the convenience sampling was used to select clients who sought family planning counselling and contraceptives at the facility. The study was conducted for four to five working days in each facility and all clients passing by were included into the sample. A total of 115 clients were observed during the service provision session. Twenty four clients out of the total number of the clients observed were also interviewed. At least two clients were selected for an interview in each facility. The exit interviews were done on the second and third day of staying in the facility when there was room in the schedule (usually the last client of the day or the last client when there were no remaining clients in the queue). At the end, the clients were categorised according to age, marital status, education level, number of children, and occupation as discussed in chapter 9. Some would argue that convenience sampling is subjected to bias. However, because the focus of study was to compare two regions and four LGAs this weakness was addressed by using the same procedure in all areas.

4.5 The qualitative methodological approach

4.5.1 General

The sources of the data for the study were documents, people and their individual behaviour. To obtain information from different sources, the data collection techniques deployed were the documentary review, in-depth interviews, observation and client-exit interviews. The triangulation of data collection techniques was done to increase the reliability of the findings. In preparation of the data collection tools, interviews with key informants, (two regional health secretaries and three LGA health secretaries) were conducted to determine the documents produced with regions and LGAs. The health secretaries made clear that regions do not prepare any plans or other documents for programme implementation. Only the local authorities prepare a CCHP document using the template designed by the Ministry of Health.

4.5.2 Documentary review

A documentary review was done to reconstruct how family planning issues are addressed in the National Population Policy, the National Family Planning Costed Implementation Programme (NFPCIP) 2010-2015 and the CCHP documents. The review assessed how and to which extent these documents addressed the core components of the family planning programme policy.

A content analysis of the CCHP document was conducted in order to establish the content of the programme, its targets and intended activities. More specifically the aim was to see what directives LGA's could derive from the document and whether they might lead to differences in local plans.

Such differences, if established, could in turn contribute to the explanation of uneven distribution of CPR across LGA's.

4.5.3 In-depth interview

In-depth interviews were conducted with a ministry official, the Regional Reproductive and Child Health coordinators (RCHco), the Regional Health Secretaries, the District Reproductive and Child Health coordinators (DRCH-co), the District Health Secretaries and health workers providing family planning counselling and contraceptives. The interviews were organised around the six properties of programme implementation, i.e, adherence, exposure, quality of services delivery, programme reach, adaptation and monitoring and control at the different levels.

The interview guide developed (*appendix 4)* was translated into Swahili. During interviews the researcher used different probes to make sure that the interviewees provided the relevant information to address the research objectives. More probing was done when there were new insights that appeared to arise from a question that was not predetermined in an interview guide. Appointments were made with a ministry official, RCHco, health secretaries and DRCHco well before the actual days of the interview. It took some days to manage to interview these managers due to the nature of their work. Sometimes, interviews were done early in the morning or even after office hours. All managers involved were interviewed except one health secretary from Musoma DC who was on study leave. Service providers were interviewed on the third or fourth day of staying in the facility after building a good rapport with them. All interviews were audio recorded after requesting permission from the interviewees.

4.5.4 Client exit interview

The exit interview was administered to the clients to assess the responsiveness of the programme to their needs. The interview was linked with observed behaviour in order to gain insight in the relationship between the *quality of services* provided and the *client responsiveness*. The information collected measured the clients' sources of information about family planning, the nature of the information they had received, their satisfaction with the family planning services received, their opinion about waiting time and their perceptions towards family planning in general and towards the services just received.The clients were interviewed after receiving the family planning services. At least two clients were interviewed in each facility. Their age ranged from 19 to 49 years. As for the level of education, it ranged from those with no formal education to those with a bachelor degree. The number of offspring ranged from zero to seven. More information about the clients' demographics is presented in chapter 9.

4.5.5 Data analysis

Numerous models for analysing policy/programme have been devised; however, there is no single model which suits all contexts (Walt et al. 2008; Cheung et al. 2010). For this study content analysis was used to analyse the Tanzania Population Policies and NFPCIP documents. The analysis started with repeatedly reading these documents in their entirety. Then the core features were recorded into excel spreadsheet to construct a goal tree. The main focus was to trace the objective-goals-means relations by constructing a goal tree with ultimate objectives, goals, intermediate goals, and means to achieve the goals (Hoogerwerf 1990) to elucidate how family planning issues are addressed in these documents and to outline what is expected in the implementation process.

The study borrowed an idea on policy documents analysis formulated by Rütten and Cheung. On that basis we created our own schema of variables that fitted the research objective under study (*table 4.3*). Rütten et al. (2003) and Cheung et al. (2010) espoused a 'logic of event' model and developed a framework for health policy analysis focusing on policy formulation and implementation. The variables designed for this study provide for a comprehensive and convincing connection between policy determinants and policy outcomes. The core concepts in the framework for analysing the policies and programme documents are: *policy background*, *existing problem*, *policy goals*, *monitoring and evaluation*, *public opportunities* and *obligation.* Each of these concepts is further elaborated in a number of sub-variables.

Table 4.3: Variables used in analysing policy and programme documents

A: Policy Background Policy/programme name Policy proposition/theory: Assumption and insight on which the policy is based The source of policy and programme
B: Existing problem that need policy/programme What is the problem(s) that the policy/programme intends to tackle
C: Policy objective, goals and means What is the central objective of the policy/programme What are the (immediate, intermediate and ultimate) goals of the policy/the programme What ways and means to achieve the goals are stated in the policy/the programme To which extent are the goals specified in such a way (quantitatively where possible and qualitative were not) that they can be subject to evaluation
D: Outcome Assessment Does the policy/programme indicate a monitoring and evaluation mechanism? What does it look like The outcome of measure are identified for each of the explicit and implicit objectives Criteria for evaluation are stated indicating indicators/measurements
E: Stakeholder involvement (Public Opportunities) To which extent are the primary concerns of stakeholders recognised and acknowledged to obtain long term support
F: Strategy for implementation (Obligations) To which extent and how the obligations of the various implementers are specified - who has to do what?

Adapted from Cheung et al. 2010.

Policy and programme background encompasses any considerations derived from scientific knowledge as the basis for policy formulation (Rütten et al. 2003). Specifically the sources may be of different types, such as authority (e.g. persons, books, articles), quantitative or qualitative analysis contained in studies of the area addressed by the policy and the programme (Cheung et al. 2010).

Problem can be defined as: an undesirable situation that according to people or interest groups can be alleviated by government actions (Birkland 2014).

Goals are conceived of as more or less detailed and precisely structured future situations that the actor of the policy wants to achieve. Goals create mechanisms that direct the policy/programme towards achievement of the final goal. A first question to be asked about a goals-means structure is, to which extent it is externally and internally consistent. External consistency refers to observations made in other situations that support the policy/programme proposal while internal consistency refers to inferences logically drawn from the available information (Bennett et al. 2007). A second question that arises is whether the goals structure addresses the policy

problem, e.g. the family planning issue. Ideally, the goal structure is designed in such a way that it is suitable for evaluation - quantitatively where possible and qualitatively if not. Thus a third analytical question is, whether the policy contains any provisions for evaluation.

Monitoring and evaluation of activities are done either by an implementer or another actor, aimed at collecting and analysing the information about the process and outcomes of the execution of the policy/programme. The concept implies the analytical question whether there are any provisions at all for evaluation in the policy/programme document and if there are, what do they look like.

Public opportunities: the policy may or may not identify the stakeholders that will be involved during its implementation. Through acknowledging the concern of different stakeholders involved in its implementation the policy might obtain long-term support.

One of the links between the objective, goal setting and successful implementation is the development of explicit means to realise the stated goals. It achieved through clear specification of the *obligations* of various implementers (Buse, Mays and Walt 2005). The analytical question is to which extent goals are provided with means.

The same procedure (content analysis) was used to analyse the CCHP document. It began by reading the CCHP document from each LGA from beginning to end. Then, the CCHP documents was re-read carefully, highlighting the text fragments that appeared to describe the plans, targets and strategies formulated by the LGAs concerning the implementation of the family planning programme.

A narrative analysis[1] was done to process stories collected in the in depth interviews, client exit interviews and during observations of services provision at health facilities. A phenomenological analysis[2] was done to describe the provider's experience in family planning provisions, clients' experiences with services received; and the behaviour of providers and clients as noted during observation.

Based on Flick (2009) the textual materials collected were analysed starting with the transcription of the recorded information, followed by coding, data reduction, data display and interpretation of different patterns.

2. Narrative analysis identifies basic stories being told by the respondents concerning their identity and their experiences with services received. It presents the story as whole (Limputtong & Ezzy 2005; Paton 2002).
3. Phenomenology analysis involve describing in details the experience of an individual in this context the individual client and health workers concerning services received or services provision (Limputtong & Ezzy 2005)

The coding referred primarily to predetermined themes from the theoretical models. Additionally, themes emerged from the data collected.

Transcription of the recorded information was done within fourty eight hours after the interview. The transcription was done in English while the interview was done in Swahili. This was followed by repeatedly reading the transcripts to cross check the quality of the data and to acquire an overall sense of the data. Thereafter, the transcribed texts were imported into the Atlas.ti programme for qualitative analysis. Within that programme, all data were coded inductively, using predetermined themes and patterns from the programme implementation model discussed in chapter 3. In addition emerging themes and patterns were deductively captured from the data. This was followed by a third phase during which the texts were coded based on the operationalisation of the programme implementation properties. Similar codes were grouped together in families that reflect chapters. This grouping was based on the units of analysis discussed in section above. Lastly, the output was created with all attached codes and quotations, memos, and families, and was then transferred to word documents. A descriptive report was created which was used to write chapters six, seven, eight and nine.

4.6 The Quantitative methodological approach

4.6.1 General

Quantitative data were collected with an observation checklist and analysed using descriptive statistics, t-test and ANOVA. A descriptive analysis was done to determine if there were mean differences between regions and between LGAs. Moreover, logistic regression was done to analyse the quality variables that were assumed to influence the clients' responsiveness to the programme and subsequently affect the CPR.

4.6.2 Data collection

Quantitative data were collected through observation of family planning services delivery in the health facilities. It involved observing the behaviour of the service providers and the clients to capture the *quality* of the service provided and the *adherence* with procedures and standards. The behaviour and activities displayed by the providers was recorded in the notebook for each client. All instances of clients being served by the health workers during the day were observed. After office hours, the observation checklist (see table 4.4) was filled out for each client separately, using a unique identification number. Observed interaction, conversations and explanations that were not included in predetermined indicators were additionally recorded in the checklist.

4.6.3 Observation checklist

An observation checklist was used to guide the researcher in collecting the data that addressed the *quality* of the family planning services provided (see table 4.4). The theoretical categories were operationalised using the National Family Planning Procedure Manual (2012) with the addition of other indicators such as 'treat client with respect', 'greet the client' and 'asks about partner's attitudes towards family planning'. The manual was written in such a way that the checklist evolved around two main concepts *clients' care*, and *counselling and education* (see chapter 3). Each of these concepts was operationalised through a number of variables which were in turn transformed into a number of dichotomous indicators for observation. In this way, the study was able to analyse the *quality of services provided* and the level of provider *adherence* with central government guidelines during service provision.

4.6.4 Client's care

This category was divided into three subcategories: 'interpersonal relations' 'routine procedures' 'and 'general client care'. All subcategories (variables) were observed using a number of dichotomous indicators. As shown in table 4.4, if an indicator was asked the column 'Yes' is ticked. When an indicator was not asked then the 'No' column is ticked.

Interpersonal relations had four indicators for observation which were: firstly, the provider sees the client in an area with privacy; secondly, the provider greets the client; thirdly, the provider assures confidentiality; and fourthly, the provider treats the clients with respect. For the first indicator (sees the client in an area with privacy), it was observed whether the provider closed the door during consultation and if the window curtains were adequately opaque so that somebody from outside could not see what was happening inside. The second indicator (provider greeted the clients) implied observing if the provider greeted the client, either using a local language or Swahili language, as a welcoming gesture. The third indicator called for observing whether the provider assured confidentiality to the client by telling her that no one would be informed about the services the client received. For the last indicator (does the provider treat the client with respect), it was observed whether the provider used positive body language such as stopping all activities she was doing when the client entered the consultation room; using polite language and listening to the client's ideas and feelings. It also involved observing if the provider excused herself whenever there was interference from colleagues or phone calls.

Table 4.4: Observation checklist for services provision at health centres

Concept		What to observe	Yes	No
A: Client Care				
1. Interpersonal relations	1	See client in private		
	2	Greet clients		
	3	Assure confidentiality to client		
	4	Treat client with respect		
2. Routine procedure	1	Review client's previous records		
	2	Ask about previous visits		
	3	Ask open-ended questions		
	4	Encourage client to ask questions		
	5	Use IEC material		
	6	Give client IEC reading material		
3. General client care	1	Check Blood pressure		
	2	Check for pregnancy		
	3	Ask about smoking		
	4	Ask about chronic health problem		
	5	Check body weight		
	6	Ask about allergies to latex		
	7	Ask about pelvic pain		
	8	Ask about vaginal discharge		
B: Councelling and education				
1. Reason for present visit	1	Ask the reason for the visit		
	2	Ask client if she want information and		
	3	Ask if the client is continues with same		
2. Asking for demographic Information	1	Current age		
	2	Marital status		
	3	Number of living children		
	4	Last delivery dates		
	5	Age of youngest child		
	6	Total number of pregnancy (Gravid)		
	7	Desire for more children		
3.Asking for client reproductive history	1	Timing for the next children		
	2	Current pregnancy status		
	3	History of pregnancy complication		
	4	Partner attitudes on FP		
	5	Client breast feeding (history)		
	6	Past family planning use		
	7	Date of last menstrual period;		
	8	Regularity of menstrual cycle.		
4. Informed choice	1	Discuss range of available methods at HF		
	2	Help client to choose appropriate method		
	3	Discuss client's method preference		
	4	Discuss effectiveness of method		
	5	Discuss how to use method		
	6	Discuss side effects of method		
	7	Discuss advantages of method		
	8	Discuss disadvantages of method		
	9	Tell the client what to do if experience		
	10	Give client method of choice or refer the		
Type of service received	1	Implanon		
	2	Pills		
	3	Depo Provera		
	4	Condom		
	5	Emergency contraceptive		
	6	Counseling only		
	7	No method received		
	8	IUD		

Information Education and Communication (IEC) are materials used in education including brochures, pamphlets, posters, cue cards, videos, billbords, radio announcements and others.

Routine procedure had six indicators: reviewing the client's previous records; asking the client a number of questions about previous visits; encouraging the clients to ask questions; using an Information Education and Communication (IEC) material; and giving the clients an IEC[3] reading material.

'Reviewing the client's previous records' implied observing whether the service provider took an initiative to retrieve client's file from the shelf and read through the past records. Asking the number of previous visits is an element of the procedure intended to check whether the client is still aware of the number of visits she had and if she remembered her last visit. By observing this, the researcher could find out if the provider was well connected with client. Moreover, it was observed if the health worker asked the client open-ended questions on general information such as the method which the client was interested in, and (in case of a new client) what the client knew about contraceptive methods. For returning clients, it was observed whether the provider asked how the client felt about the contraceptives and if she experienced any problem with the methods she used. 'Encouraging the client to ask questions' implied observing if the provider encouraged the client to ask questions after an explanation on aspects of family planning. The last indicator observed in the routine procedure was whether the provider used the IEC material, and whether she gave the client these materials to read at home. The concern here was to observe if the provider during counselling used cue cards, models of female and male reproductive organs and brochures or posters to describe how the methods work.

The last variable observed in the *client's care* category (*general client care*) was operationalised in eight indicators: provider checking the client's blood pressure; checking or asking about pregnancy; asking about smoking; asking about chronic health problems; checking body weight; asking regarding an allergy to latex; asking about pelvic pain; asking about vaginal discharges.

4.6.5 Counselling and education

Regarding the *counselling and education* category, there were four variables: the service provider asking the client reason for present visit; asking for demographic information; asking for client's reproductive history; and client's informed choice.

4. Information, Education and Communication (IEC), are materials used in the process of informing, educating and communicating issues to clients for behaviour change towards family planning. These materials include brochures, pamphlets, posters, cue cards, videos, billboards, radio announcements and others (National family planning procedure manual 2011).

Starting with the *reason for the present* visit, three indicators were applied: the provider asking the reason for current visit; asking the client if she wanted more information and counselling; and asking if the client is continuing with the same method. Observation was done to see if the provider questioned the client specifically with the aim of visiting the family planning unit, if she is to start using family planning methods for the first time, continuing with the methods, changing or stopping a method.

The variable *'provider asking for demographic information'* has seven indicators: current age; marital status; number of living children; last delivery dates; age of the youngest child; total number of pregnancy; and desire for more children. These indicators are object effect (i.e. either it is asked or not). The observation was done and if the provider asked about this indicator it was recorded 'YES' and if she did not ask it was recorded 'NO'.

In addition, asking for *client reproductive history* had eight indicators: timing for the next children; current pregnancy status; history of pregnancy complication; partner attitudes on family planning; client's breastfeeding history; dates of last menstrual period; and regularity of menstrual cycle.

The *client informed choice* had ten indicators observed: the provider discusses a range of available methods at the health facility; helps the client to choose appropriate method; discusses effectives of the methods selected. Other indicators observed include, the provider discusses how to use a method; discusses side effects of the method; discusses advantages of the method; discusses disadvantages of the method; tells the client what to do when in case of problems with the method; provides the client with the method of choice; and refers the client for the method of choice.

The observation checklist also incorporated the services client received after *client care* and *counselling and education* session. The methods and services observed include the condom, pills, emergency contraceptive, injection, implants, Intra Uterine Device (IUD), counselling only and no methods received. However, the emergency contraceptive was not provided in all facilities studied.

Seven indicators from an observation checklist (highlited indicators in table 4.4) were removed for further analysis due to different reasons. One indictor in routine procedure: giving clients the IEC reading materials was removed since it was done with Moshi MC only. The six indicators of the *general clients care* variable were removed as well because they hardly manifested themselves during the observations.[4] Health workers in Moshi MC and

5. The indicators are; check for pregnancy (observed twice), ask about smoking (observed six times) , ask about chronic health problems (observed nine times), ask about allergies with latex (observed seven times), ask about pelvic pain (observed three times) and ask about vaginal discharge (never observed).

Moshi DC took some initiative to ask the clients about their general health condition while the health workers in Musoma MC and Musoma DC did not. In addition, it was noted that only the health workers in Moshi MC handed out the IEC materials (brochures) to clients coming for family planning services.

4.6.6 Data analysis

Descriptive statistics were used for presenting results from the quantitative data gathered from observation sessions. The indicators were coded and recorded in an excel spread sheet where the indicators that were scored 'YES' were coded as '1' and those which scored 'NO' were coded as '0'. Then the data were imported into SPSS for further analysis.

Cronbach's alpha test was performed to measure the internal consistency of the scales. The Cronbach's alpha test was done with an aim of ensuring that all indicators transformed measure the same underlying construct. The Alpha coefficient values ranges from 0 to 1 and is used to describe the reliability of factors extracted from dichotomous and Likert scale variables. The higher the score, the more reliable the generated scale: the 0.7 (70%) values indicate an acceptable reliability coefficient.

From table 4.5 we can see that the Cronbach's alpha for interpersonal relations, routine procedure, general client care, reason for present visit, asking for demographic information, asking for client reproductive history and client informed choice are above 70% showing that all indicators in this variables were measuring the same underlying construct.

Table 4.5: Reliability Statistics for organisational commitment

Concept	Cronbach's Alpha	No. of Indicators
Interpersonal relations	0.70	4
Routine procedure	0.72	5
General client care	0.77	2
Reason for present visit	0.76	3
Asking for Demographic information	0.87	7
Asking for client reproductive history	0.85	8
Informed choice	0.92	10

The indices of the *client care* and *counselling and education* variables were constructed for all relevant variables, with values ranging from 0.00 indicating very poor to 1.00 indicating excellent implementation of the family planning programme as required by the manuals (procedures and guidelines).

A *t-test* was performed to compare the mean differences for the two regions (Kilimanjaro and Mara) in *client care* and *counselling and education*

to see if there were significant mean differences. The three variables in *client care* and four variables in *counselling and education* were compared across the regions. Furthermore, the analysis of variance (ANOVA) was done for the four local authorities, Moshi municipal council, Moshi DC, Musoma MC and Musoma DC for the two concepts, *clients' care*, and *counselling and education*.

Client care and *counselling and education* are the activities performed by the provider during provision of family planning services. These are predetermined procedure that should be followed by the provider during family planning services provision (URT 2012). The variables of the *client care*, and *counselling and education* categories were treated as outcome variables while the region and local authorities were independent variables.

Further analysis was done to examine the implementation factor(s) influencing the Contraceptive Prevalence Rate (CPR). The two regions included in this study were selected based on the DHS 2010 report either having the highest CPR or the lowest CPR. Being a dichotomous outcome, the use of binary logistic regression is necessary, which is the mostly used model to analyse the probability of an event to occur. A positive regression coefficient will mean that the explanatory variable increase the probability of the outcome, while a negative regression coefficient means that variable decrease the probability of that outcome. Lastly, a large regression coefficient means that the risk factor strongly influences the probability of that outcome; while a near-zero regression coefficient means that risk factor has little influence on the probability of that outcome.

4.7 Pilot study

A pilot study was conducted that examined the implementation process throughout the hierarchy, starting at Kilimanjaro regional office, down to the Moshi MC office and then to one of the health facilities in the same council. A full fledge study was done deploying all data collection tools for seven working days, conducting the analysis and evaluating the results. The pilot study showed that three days were sufficient to grasp the performance of the provider. Also, the information gathered during observation reached a threshold and started to repeat itself after three days. Therefore, the number of days for data collection in the facility was reduced to four-five working days. The pilot study confirmed that the local authorities did not prepare any documents that explained the family planning programme implementation plans. They prepared only the Comprehensive Council Health Plan (CCHP). Therefore the documentary reviews were limited to this document.

The initial plan was to select the health centers with the highest and the lowest CPR in each local authority. However, the majority of councils in Tanzania have two or less health center(s). Moreover, the DRCHco and council Health Secretary pointed out that they do not categorise their

facilities according to acceptance rates since they all have different catchment areas with a different population size. Also, the initial plan was to group the clients in different strata in terms of age, marital status, education level, number of children, and occupation; and use a stratified sampling procedure to select the clients in each stratum. However, in the pilot study it was found that there were days when no health workers showed up for family planning services, while on other days they attended either new clients or follow up clients only. So, the pilot showed that stratification would not work out. Therefore, minor changes were made in the observation checklist and the interview guide to hone the tools. For instance, it turned out that the DRCHco, the health secretaries and the providers were unable to answer a question about the CPR in their area. Later on, it became clear that they do not think in terms of CPR (the eventual outcome of their work) but in terms of acceptance rate (the immediately observable effect of their work).

4.8 Accesses and privacy

The proposal to conduct the study was developed at the University of Groningen in the Netherlands. The Directorate of Research, Publications and Postgraduate Studies at Mzumbe University in Tanzania where the study was conducted endorsed the introductory letter. In addition, Kilimanjaro and Mara Regional Administrative Secretary (RAS) offices granted the clearance and introductory letters to conduct the study in their regions. Further, District Health Secretary (DHS) and District Reproductive and Child Health Coordinator (DRCHco) granted the approval in Moshi municipal council. Whereas, at the Moshi DC the District Medical Officer (DMO), DHS and DRCHco endorsed the clearance after submitting the introductory letter from RAS office. At Musoma MC and Musoma DC the procedure was a bit long. It started from District Administrative Secretary (DAS) of both LGAs followed with another approval from Musoma Municipal Director and Musoma District Executive Director. Lastly was approval from DMOs, DHS and DRCHco of Musoma MC and Musoma DC. At the Ministry of Health and Social Welfare, Reproductive and Child Health department granted the clearance to conduct study at the ministry level.

The interviewed and observed respondents gave verbal consent and confidentiality was ensured to them. Prior to interview and observation, the respondent was clearly informed that she was entitled to refuse to answer any question and that she could decide to withdraw from the study any time she wished without any consequence. The respondents were assured that the information collected was used for the purposes of the study and not otherwise. They were further informed that the information collected was not aiming at helping them directly, but that it could benefit many other people in the future because it might help the programme managers and policy makers to improve implementation of the family planning programme. In addition,

they were informed that the information from interviews and observations were confidential, and that the analysis of the data would be done anonymously. A potential obstacle for effective interviewing was the fact that the researcher is male while the subject matter of the observed interaction and of the interviews was delicate. Yet the introduction made by the health worker at the family planning unit created the condusive environment that enabled the researcher to collect the data without a problem. To ensure the anonimity of the respondents, each respondent was assigned the unique identification number starting with P1, P2, P3…P40. under which numbers the interview reports and observations were filed. The particulars of the respondents are kept in a separate confidential file.

Chapter 5

Document analysis of the family planning related policies in Tanzania

5.1 Introduction

Policies are supposed to provide a foundation on which to build strong health systems, programmes and service delivery systems, according to the Health Policy Initiative (Task Order I 2010). If this is true than it is striking that relatively little research has been done about the content and the quality of founding health policies or about the implementation of those policies. Much work has been done on population planning (Miro and Potter 1980; United Nations 1987; Mueller 1993; Eager 2004; May 2012) and policy development (Walt and Gilson 1994; Colebatch 2006). Less attention has been paid to policy document analysis and how policies are implemented (Thomas and Grindle 1990; Saetren 2005; Hill and Hupe 2009; Pritchett, et al. 2010).

However, there is one publication (Hardee 2013) that focuses on policy document analysis. The publication appeared at the same time that the present study was conducted. The Hardee analysis found that the Tanzania's 2006 National Population Policy implementing agencies and their roles are spelled out in the policy document with the implication that implementation would be the collective responsibility of all ministries in Tanzania. The *National Family Planning Costed Implementation Programme (NFPCIP)* contains a detailed breakdown of contraceptive needs and costs. It also contains a section on institutional arrangements, and includes multisector engagement and a specification of actions to be done either at the central government level or at the LGA level. Hardee acknowledges the multiplicity of the policies, which involve a wide range of stakeholders at many levels in the country. The paper ends up calling more evaluation studies analyse and document the policy implementation process and highlight the effect that policy implementation has on family planning and reproductive health programmes.

Most of the studies on policy analysis are either retrospective or prospective. Retrospective studies are looking back to understand why and how the policy found its way into the public agenda, how it was designed and decided upon and whether it achieved its goal. Prospective studies explore how a policy might be introduced and accepted by actors who will be affected by it (Buse, Mays and Walt 2008).

The present study has the ambition to discover whether diversions of implementation practices from a policy-as-designed can explain differences in policy success. In order to be able to do so, the content of the policy-as-

designed needs to be established first. Therefore, in this chapter a reconstruction is made of that policy, answering the question of how family planning issues are addressed in the National Population Policy documents and National Family Planning Costed Implementation Programme document (NFPCIP) 2010-2015.

The aim of the policy and programme documents analysis is to gain an understanding of the core quality of the policy and the programme as conceived and put into language by the actor of that policy and programme. The reconstruction of the policy framework will be the starting point for the research into the implementation process of policy/programme at central government, LGAs and at health facilities. Differences in Contraceptive Prevalence Rate (CRP) between the regions in Tanzania could not be solely attributed to traditional demographic factors as discussed in chapter 2. Therefore, research into the implementation of the policy/programme seeks to provide an alternative explanation for the achievement of the policy's intents (success or failure of Tanzania's population policy and family planning programme).

The original purpose for enacting the National Population Policy 1992 was to strengthen the family planning programme (Richey 1999). It was expected that the policies would be published and engineered by the Ministry of Health and Social Welfare, since the family planning programme was defined as health intervention rather than a demographic intervention. Moreover, it was integrated in the Family Planning, Maternal, Newborn and Child health Department under MHSW (Richey 2008). Nevertheless, the President's Office and the Ministry of Planning, Economic and Development published it. As the policy was issued by the Ministry of Planning, Economic and Development, they accentuated development rather than just addressing population issues.

According to the preamble of the policy, the country was having a development problem rather than a demographic (population) problem. This opinion was already expressed at the World Population Conference 1974 in Bucharest where Tanzania was one of the vocal third world countries insisting that the focus of the conference should be on the development problem rather than on the population problem (Mkini 1980). The ideology was: 'take care of development and population will take care of itself' (Richey 2009). Since 1974, donors (ILO and INFPA) had been funding and conducting seminars to provide Tanzanian government officials with an opportunity to understand and discuss population issues. During the economic crisis facing Tanzania in 1980s it was forced to adopt population policy as a condition from the donors. After a long discussion between the Tanzanian government and UNFPA, the government organised high-level seminars for religious leaders and policy advocates in 1989. Former President Nye ere chaired two of these seminars, with the then president, Mwinyi and all top government leaders

attending. In 1990, another meeting was conducted to bring together religious leaders, but the Roman Catholic Church refused to attend, (Richey 2009). Finally, in July 1992 the policy was adopted.

5.2 Policy documents analysis

In recent years, policy analysis especially health policies of low and middle-income countries are gaining considerable attention in the published policy analysis literature (Gilson and Raphaely 2008). However, it is hard to find studies that apply policy document analysis especially for health policies in Sub-Saharan countries. Gilson (2008) conducted a review of studies published in journals between 1994 and 2007 in the area of health policy analysis in low and middle-income countries. He managed to review 164 articles in detail and found that most of them had a stronger focus on earlier stages of policy development rather than on implementation. Moreover, the articles were presenting broad descriptions of experiences on the national level. Few articles analyse the implementation of policies or the views and experiences of implementing actors. Other papers consider general implementation in a specific policy area, including advocacy.

The analysis of policy documents is an approach to identify the core quality of a policy as conceived and put into language by the actor of that policy. Policy documents do not always totally reflect how policy is actually conducted. One reason is that the designers of the policy usually are not responsible for its implementation and often are not stakeholders in the problem the policy seeks to address (Cheung et al. 2010). Also, a policy-on-paper sometimes may not reflect the true intention of the actor of that policy. The policy document may serve other purposes than outlining a course of action: satisfying the urges of donors, pacify political adversaries and hide true intentions (Barrett and Tsui 1999).

It is argued that policy document development is that part of the policy process that enables goals, opportunities, obligations and resources to be recognised. The policy document may serve two main purposes: (1) an instruction on how best the policy will be implemented in a way to fulfil its goals, and (2) during its implementation to monitor progress and ensure that the implementation process stays on track (Cheung et al. 2010). The policy implementer will usually have the policy document at hand as a guide for implementing the policy. Sometimes the implementer may not have sufficient background in the policy area itself. Then the policy document is supposed to show who will do what, when and how.

This chapter is not intended to initiate an analysis of the effectiveness of the population policies under scrutiny. Rather it examines how family planning issues and intended outcomes are being addressed in the Tanzania National Population Policy and NFPCIP documents. In doing so, a reconstruc-

tion was made for the policies that are supposed to form the frame of reference for the implementers who are set to realise the intended outcomes.

5.3 Policy background

5.3.1 Organisation of the policies

The National Population Policy 1992 has four chapters. The first chapter starts with a brief profile of the Tanzanian population, sources of population growth, consequences of rapid population growth and goals of the policy. Chapter 2 discusses the relationship between population growth and development of sectors. Chapter 3 addresses the problems of special groups in society such as women, children, youth, the elderly and disabled. Lastly, chapter 4 elaborates on the goals and responsibility of different sectors.

The revised policy (2006) has six chapters. Chapter one contains an introduction and principles to guide the policy implementation. Chapter 2 provides a general overview on population and development. Chapter 3 provides justification of the new population policy assessing previous achievements, constraints and limitations, new developments, continuing challenges, major concerns in population and development. Chapter 4 explains policy goals, objectives, issues and policy directions. Chapter 5 describes the institutional arrangements, roles of sectors and responsibilities of stakeholders. Lastly, chapter 6 provides a planning, a monitoring and evaluation framework, the priority action areas for monitoring and evaluation and indicators for monitoring and evaluation.

5.3.2 Title and publisher of the policies

The name of the policy document published in 1992 and that of the revised version published in 2006 is the same: 'National Population Policy'. The President's Office planning commission published the first National Population Policy 1992 and the Ministry of Planning, Economy and Development published the revised policy of 2006.

5.4 National population policy 1992

5.4.1 Scientific basis for policy formulation

According to Richey (1999) the introduction of the Tanzania National Population Policy was meant to strengthen family planning services delivery (USAID 1994). The policy was the result of the World Bank report (1988), describing that Tanzania has had a population problem since its population was growing faster than its Gross National Product (GNP). The World Bank

(WB) supported the government in the preparation of the policy and provided the funds for its implementation (Richey 1999).

However, the policy introductory message stipulates a policy goal that differs from the donor organisations' perspective (strengthening family planning). For instance, prime minister and then first vice president, J.S Malecela in the Foreword stated:

> *'The main goal of the National Population Policy is to extend the horizon of the country's development plans whose principal objective is to move Tanzanians away from poverty and extend their horizon of standard of living.'* (National Population Policy 1992, p. iii).

The same was articulated by the vice chairman of Planning Commission and Minister of State S.A Kibona.

> *'Tanzania's fundamental national goals and development strategy are largely inspired by the Arusha Declaration and have clearly been reflected in the successive national development plans.'* (National Population Policy 1992, p. v).

This difference between the donors who stressed demographic goals and the Tanzanian government that stressed the development goals can be seen throughout the policy document (National Population Policy 1992).

5.4.2 Policy objectives/goals and means to realise the goals

The principal objective of the National Population Policy (1992) was: 'reinforce national development through developing available resources in order to improve the quality of life of the people'. Special emphasis was given to 'regulating the population growth rate; enhancing population quality;[1] improving the health and welfare of women and children'. Specifically, the policy was set to achieve the following as quoted from the policy document:

1. Promote the development of the population as a nation's resource in order to ensure effective deployment of human resources in socio-economic development,
2. Improve the standard of living and the quality of life of the people through protection and improvement in the provision of basic human needs in such areas as health, nutrition, clean and safe water, housing and environment,

1. This is direct quote from the policy document. This probably should read: 'enhancing the quality of life of the population'

3. Promote improvement in health and welfare of mother and child through the prevention of illness and premature deaths,
4. Strengthen family planning services in order to promote the health and welfare of the family, community and nation and eventually reduce the rate of population growth,
5. Promote sustainable relationships between population, resources and environment,
6. Promote a more harmonious relationship between rural, urban and regional development in order to achieve spatial distribution of the population conducive to the optimal utilisation of the nation's resources,
7. Promote and strengthen proper youth upbringing and growth including the creation of an environment that will allow optimal development of their various talents, and
8. Urge the society at all levels to ensure that the elderly and the disabled are accorded due respect, care and assistance in securing reliable means of sustaining their lives.

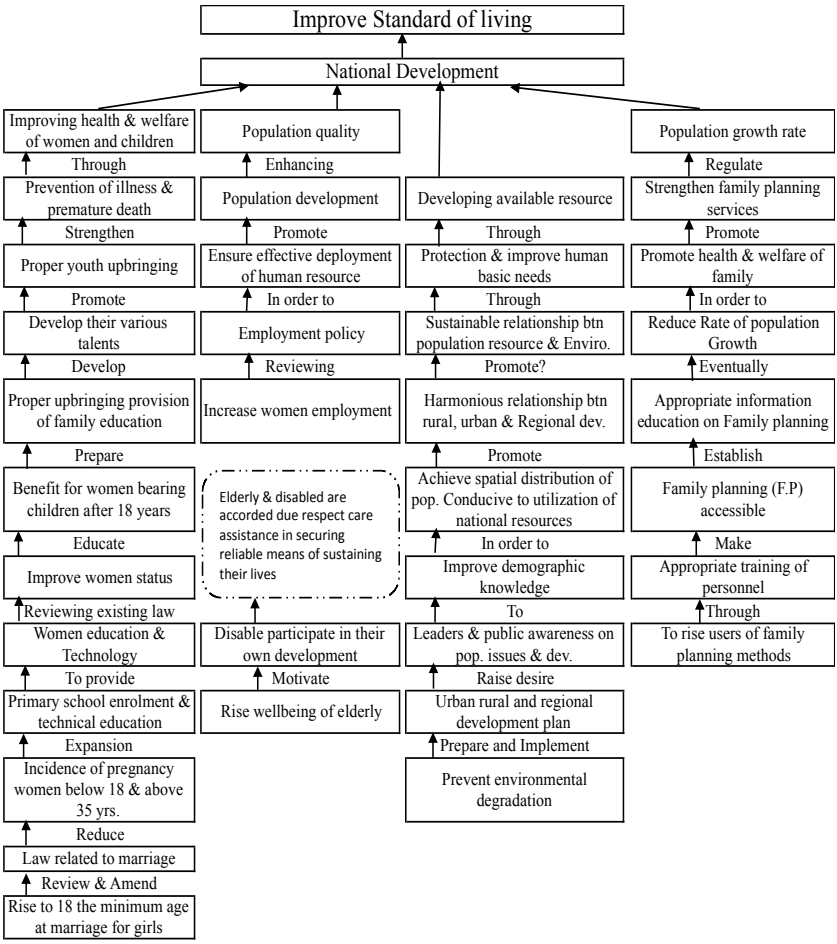
The National Population Policy 1992 was reconstructed quoting the sections as they were written in the policy document (figure 5.1). The reconstruction shows the objectives and the goals–means relationships. The reconstruction makes apparent that the policy contains many goals but specifies very few means to realise the stated goals. Objectives were addressed by the words, 'To regulate', 'To improve', 'To provide', and 'To rise'. The more concrete goals are addressed with different verbs, 'In order to', 'Eventually', 'Establish', 'Make', 'Promote', 'Raise desire', 'Prepare and implement', 'Prevent', 'Increase', 'Rise', 'Prepare', 'Educate', 'Expansion', and 'Reduce'. To indicate the means to realise the goals the following words were used: 'Through', 'Reviewing', 'Motivate' and 'Amend'.

The goals explained in the policy document lack explicitly stated targets to be achieved in a specified period of time. Only for very few goals the required target is exactly stipulated. One such goal for instance is to raise the minimum age for a first marriage of girls to eighteen years. Another goal is to raise the number of users of family planning methods, without stating clearly by what percentage. Moreover, most of the goals are not elaborated with means for realizing those goals. For a few however, means are indicated. An example is*:* 'increasing family planning *through* appropriate personnel training'.

The 'regulation of population growth' was the only objective for which clear intermediate goals have been formulated, stipulating what was to be achieved. The document outlines a string of intermediate goals: to reduce population growth *by* making family planning services accessible *through* appropriate training of personnel and *by* eventually rising the usage of family planning services. For other goals such as operationalisation, intermediate

goals and means were lacking. For instance, one of the policy goals was to 'promote and strengthen proper youth upbringing'. There was no link however with another statement: '*develop* their various talents *through* 'proper upbringing of youth *by* provision of the family education'. This statement means that the talent of youth was to be developed through provision of family education. This begs the question of how family education would develop talent within the youth.

Figure 5.1: Objective, goals-means relationship for population policy 1992



Source: Constructed by researcher from policy document

In summary: the policy addresses the family planning issues clearly, starting with the existing problem 'overpopulation'. Moreover, the policy highlights desired goals to be achieved, increasing the use of contraceptives (CPR) *through* (means) making family planning services accessible and *through*

appropriate training of personnel. The policy lacks clear targets as to what extent and in what period of time these goals have to be achieved.

5.5 National population policy 2006

5.5.1 The policy theory and backup evidence

The reviewed policy 2006 states clearly the constraints and limitations that supposedly hindered the implementation of the 1992 National Population Policy (Population Policy 2006 p. 8). As cited from the policy:

1. Inadequate trained human resources at all levels of implementation
2. Inadequate financial and material resources
3. Inadequate availability of age and gender disaggregated population related data
4. Non-establishment of planned policy coordination and implementation arrangements
5. Policies mainly addressed family planning and child spacing activities; this influenced limited participation of players in other reproductive health issues.
6. Placing more emphasis on meeting demographic targets rather than the needs of individuals (males and females)
7. Inadequate recognition of the relationship between poverty, population, environment, gender and development
8. Inadequate advocacy to guarantee the required support for population and development issues
9. Insufficient capacity and resources of NGOs engaged in population related activities

Moreover, the document explains the challenges that necessitate the review of the policy (p 10) as (quoted from policy):

1. Increased forms and levels of gender-based violence, traditional harmful practices including FGM, sexual abuse, neglect and abandonment of children
2. Need for relevant and affordable quality education and training at all levels
3. High prevalence of STIs, HIV and AIDS
4. High levels of adolescent pregnancies and early childbearing
5. Frequent pregnancies and deliveries
6. Increasing unemployment due to poor economic performance
7. parallel with rapid labour force growth
8. Persistently high maternal, infant and child mortality
9. Rapid and unplanned urban growth

10. Low status accorded to women in society
11. Inadequate programmes to address specific reproductive health needs of particular population groups
12. Increased incidence of drug and substance abuse
13. Increasing needs of disadvantaged groups, including orphans

The information used in the introductory part of the policy (2006) emanated from different surveys conducted in Tanzania, especially the Tanzania Demographic and Health Surveys. Moreover, it grasps some information from the Population and Housing Census 2002. The information about limitations and challenges was derived from these surveys and census. The policy lacks other back up evidence either from research conducted within and outside Tanzania on the issue of population and development, or other research as underlying rationale for revising the policy document and the theories that guide its implementation.

5.5.2 Policy objectives, goals and means

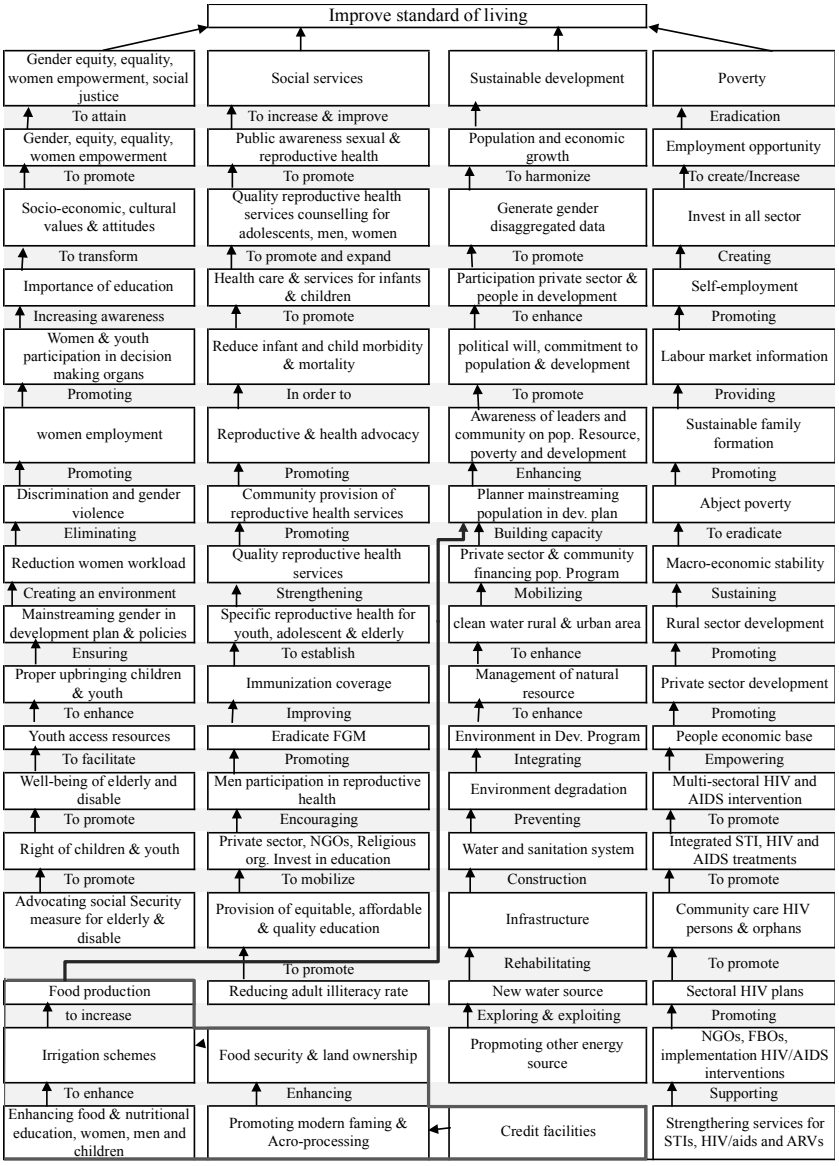
Figure 5.2 contains the goal tree of the 2006 policy. The reconstruction was based on the same procedure as applied for the 1992 policy, exactly quoting the wording of the document. As can be seen in the figure, among four specific goals of the policy, two goals address development while the remaining two address gender issues and the relation between population and environments. None of them addresses family planning issues directly.

The Population Policy 2006 has incorporated new sectors and more issues compared to the previous one (see *figure 5.2*). The objective is clearly stated, starting with the word 'To…' However, the goals and means to realise the expected objectives are difficult to recognise, due to the way action verbs are structured. The verb 'Promote' has been used for about one third (24 times) of all verbs used (64), altering it by adding the prefix *-ing*. Of other verbs used it is not clear if they are referring to goals or means. Examples, *'creating', 'providing', 'sustaining', 'empowering', 'supporting', 'strengthening', 'enhancing', 'building', 'mobilizing', 'integrating', 'preventing', 'construction'*.... The verb 'promotes' literally means, 'encourage growth and development: further something by arranging or introducing it or to advance to a higher level or position'. The frequent use of the word 'promote' poses the question what was exactly the policy document aim? Is it encouraging, introducing or advancing the objective, goals and means?

Furthermore, the objectives and goals are broad and lack clear means to achieve them so it remains unclear how the implementation of the policy is supposed to take place. Examples are: 'to promote the public awareness on sexual and reproductive health'; 'to promote and expand quality reproductive health services counselling for adolescents, men, and women'; 'to promote healthcare services for infants and children'. The intermediate goal for these

objectives is ‘in order to reduce infant and child morbidity and mortality’ but the means to realise this goal are not outlined. Is it through, ‘promoting reproductive and health advocacy’ or not?

Figure 5.2: Objective, goals-means relationship for population policy 2006



Source: Constructed by researcher from policy document

Generally, the policy addresses 'everything' from gender equity, equality and women's empowerment, to improving social services, sustainable development and poverty eradication. 'Family planning services' as a policy topic was included in the broad category, 'Reproductive and Child Health'. It is different from the first policy in that it has clearly stated goals on family planning. The goal was 'to increase the Contraceptive Prevalence Rates in order to overcome the population problem (overpopulation)'.

5.6 Implementation Strategy

The 1992 policy document stipulated that the implementation was to be done by the ministry departments and various other organisations that were to assume their responsibilities as outlined in the policy. Each ministry was assigned specific tasks to perform in order to realise the policy goals. However, the document did not contain clearly stated goals and targets to be realised by the respective units.

According to 2006 documents, both government agencies and organisations from the civil society and the private sector are designated as implementers of the policy. Specifically, the governmental implementing agencies including the following: the Tanzania Council on Population and Development (TCPD), the National Population Technical Committee (NPTC) and population desks in all relevant ministries and at regional and local government authority (LGA) levels.

The newly installed Tanzania Council on Population and Development (TCPD) is listed to be the overall co-ordinating and advisory body for the implementation of the policy. Council members would be the Permanent Secretaries of the relevant ministries, and the executives of relevant institutions, i.e. the Tanzanian Parliamentarians' Association on Population Development (TPAPD), Non-Governmental Organisations (NGOs), the Parliamentarians' Group on HIV and AIDS and the Tanzanian Commission for AIDS (TACAIDS). The council chaired by the minister of planning, economy and development.

5.7 Monitoring and evaluation

The 1992 National Population Policy did not have a monitoring and evaluation provision; therefore, the analysis of this item focused on the revised version. The policy document explicitly states that:

> *'Monitoring and evaluation are important components in the process of implementing the National Population Policy. They track implementation progress that enables the stakeholders to take informed decisions so as to achieve the stated objectives and demonstrate results for accountability'* (National Population policy 2006 pg. 34).

However, whilst the National Population Policy has set out a number of objectives and goals to be achieved, it lacks specified specification of the means for monitoring and evaluation of the realisation of the goals and targets. The policy document continues with the statement that:

> *'The implementation of the National Population Policy involves and will involve many actors, each of them will develop and apply the monitoring indicators necessary for tracking progress on everyone's area(s) of mandate.'* (National Population policy 2006 p. 34*).*

For example, the coordination for poverty eradication is assigned to the Ministry of Planning, Economy and Empowerment, which is the same ministry that is expected to develop monitoring indicators for that area. The policy document further states 'monitoring indicators required for many of the priority areas for action are already in place'. The document does not give any examples of the monitoring and evaluation indicators. Apparently, the policy maker just assumed that the indicators were in place, an assumption that may not have been realistic.

5.8 Concluding remarks

The first part of this chapter analysed the Tanzanian Population Policy to gain an understanding of the core quality of the policy as conceived and put into language by its actor. The central finding of the previous analysis is, that both policy documents contain quite a number of sometimes far reaching goals, without specifying concrete targets to be reached or ways and means to achieve those goals. Thus the policy documents give little indication as to any trajectories for the implementation of the policy. How can this be explained? One interpretation of this state of affairs can be derived from international studies on population policies.

International comparative research has shown that the presence of a stated family planning policy does not necessarily imply that the government is indeed committed to family planning. There are countries without a stated policy that have well developed programmes; while other countries have a declared policy and weak programmes. However, adoption of a policy is communicating to local constituents as well as to the international organisations that the country supports population programmes (Barrett and Tsui 1999).

The population policies adopted over the past several decades in various African countries not only represent governments' commitments to internal change, but are also a sign of their alliance with the international community that is concerned with population growth. It was hypothesised that the adoption of a population policy was meant to incite support from the international

community (Barrett and Tsui 1999). Findings from the study conducted by Barret and Tsui (1999) show that the demographic factor, economic and political factors and population policies all increase the likelihood and the amount of USAID funding for population projects in 114 developing countries.

The introduction of the Tanzanian National Population Policy (1992) was meant to strengthen the delivery of family planning services (USAID 1994). The policy was the result of the World Bank Report 1988 statement that, 'Tanzania faces a population problem, and needs preparation of a National Population Policy'. The World Bank (WB) supports the government in preparation and provides the fund for its implementation (Richey, 1999). Furthermore, the new policy (2006) explains clearly that the aim of revising the old policy among others is to abide with new international developments, especially after the 1994 Cairo International Conference on Population and Development (ICPD).

From this perspective, the policy seems a '*symbolic'* expression (Barrett and Tsui 1999), meant for the international community, a message that the country takes population control seriously. For a proper understanding of the implementation process of the family planning programme the need for analysing NFPCIP arises. This programme document should much better reflect the country's intentions in implementing a family planning programme. Moreover, it is the document that identifies the activities to be implemented and the resources required.

5.9 National Family Planning Costed Implementation Programme (2010-2015)

5.9.1 Organisation of programme

The programme document has three sections written in thirty-four pages. Section one is an introduction that explains the background of the programme development. It elaborates on programmes and resources for health and on family planning services and issues and discusses the challenges of the previous family planning programme. Section two addresses the purposes of the NFPCIP, vision, mission, goals, and objective of the programme; an analysis of demographic determinants, resources required and strategic actions necessary to achieve the objectives. Section three lays out a resource mobilisation framework, the required monitoring and evaluation and a plan for implementation. Lastly the document has six attached appendixes: 2009-2010 family planning partners and implementers; summary report of the key informant interviews and advance consultation; summarised process for development of NFPCIP; definition of terms used in the NFPCIP and analytical framework; annual resource requirement by strategic action area and bibliography.

5.9.2 Title and publisher of the programme

The name of the programme reflects exactly what is deemed as implementation of family planning programme. The writer of the document is MoHSW which also implements it through a different department in the ministry from central level to the community level.

5.9.3 Scientific ground for programme formulation

The programme document stipulates that it was developed in line with Reproductive and Child Policy Guideline 2003; National Road Map Strategic Plan to Accelerate Reduction of Maternal; New-born and Child Deaths in Tanzania 2008-2015; and Health Sector Strategic Plan III (HSSP). Moreover, the writer conducted a series of key informant interviews and advance consultations with government officials; donor agency representatives; representatives from the public; NGOs; FBOs; private health facilities offering family planning services and academician. The interview was aiming to address three key issues; '*reason for loss of momentum of Tanzania's family planning programme, specific concerns about areas of programme performance and suggested interventions to reposition family planning'*. This information was supplemented by reviewing 84 pieces of literature from different scientific journals, books and reports on family planning programmes all over the world.

5.9.4 Programme objectives, goals and means

The programme has five objectives to realise the target. Firstly, ensuring contraceptive security and strengthening integrated services in the delivery of family planning, in all aspects of the health sector. Secondly, building the providers' capacity to deliver and support safe use of family planning and services. Thirdly, strengthen service delivery systems. Lastly but not least, advocacy to increase visibility and support for family planning as a key investment for improving the lives and well-being of all Tanzanians. Lastly, strengthen the health system's management and the monitoring and evaluation of the national family planning programme. However, the document states clearly that emphasis will be in two areas, ensuring contraceptive security and strengthening integrated services in the delivery of family planning in all aspect of healthcare.

From the goals-means tree (figure 5.3) it is clear that the goal of the programme is to increase CPR from 28% to 60% by 2015. Each objective has clearly separated strategic actions (means) to achieve it together with clear targets, resource required (human resource and finance), the responsible units and time limit. The programme is so detailed that to some extent it has the potential to restrict the creativity of the implementer. Moreover, when considering the way in which the programme is structured, it appears most of the

activities are done within the high authority (ministerial level) and little is left to regions and LGAs. For instance, looking to the strategic action in contraceptive security, advocacy and health systems management, one finds a structured approach as to how the ministry or Family Planning Working Group official will implement it.

Figure 5.3: Objective, goals-means for NFPCIP 2010-2015

Source: NFPCIP 2010-2015

Increase the CPR from 28% to 60% by 2015	
Reinvigorated	Strengthened
Advocacy to increase & support F.P	Health systems management and M&E
- Review mechanisms of FP budgetdevelopment and resource-allocation systems	- Organize and conduct a 1-day initial alignment meeting for 60 key persons from national, zonal, regional, and district levels to generate necessary support for the LDP
- Advocacy meetings involving key stakeholders, PMO-RALG and MoFEA officials leading to establishment of a separate FP budget line item at national, regional and district levels	- Organize and deliver the LDP in three 5-daya workshops for six teams of five from central, zonal, and regional level RCH staff
- Conduct a consultation meetings to ensure inlusion of FP in major national policy documents, strategies and plans	- LDP-trained teams prepare for, present results achieved by implementing action plans in a 2-day meeting for key stakeholders
- Mapping of development partners interested in supporting FP	- Conduct internal, external study tours to FP providers to learn best practices
- Develop, implement FP resource allocation advocacy strategy targeting development partners	- Support RCHS staff to attend FP courses and national/international meetings
- Organize two 1-day meetings per year involving FP stakeholders on repositioning FP	- Procure a vehicle for RCHS
- Conduct one national relaunch of the Green Star logo by high-level government official	- Conduct rapid assessment of FP services/data, report to key regional and district staff to guide design of new reporting framework
- Prepare, produce, broadcast radio spots radio soap opera "Zinduka program"	- Establish framework, guide, methods for collecting and reporting RCH?FP data at district and regional levels
- Produce, distribute revised print materials to all clinics and training centres	- Provide training at regional and district levels in strategic planning, using data to set realistic goals, plan and monitor program activities
- Conduct FP campaigns in all ongoing health campaing and national festivals	- Develop, implement executive dashboard to monitor FP program, NFPVIP implementation
- Revive/orient FP media group to support a multimedia dissemination campaign	- Conduct monthly National FP Working group meetings
- Orient DRCHCo and RCHCo about the champions initiative	- Revive and maintain RCHS Web site
- Train zonal trainers on champions approach	- RCHS participates in annual coordination meetings with zonal level
- Support, follow-up districts/regions on the process to identify, select and recruit champions	- Mapping of current FP system - who (public, CSOs, NGOs, FBOs) is doing what, where when
- Identify, select, recruit champions via consultations between RCHS and National FP working group and other stakeholders	- Disseminate results of National Family planning subaccounts And identify gaps and opportunities for increasing FP financing
	- Disseminate information in ongoing forums at national, regional and district levels to enable coordination of activities and share lessons learned; engage policy makers, donors

Source: NFPCIP 2010-2015

5.10 Implementation strategy

The programme document specifies that the programme implementation were to be under the leadership and management of existing institutions at all levels of the health system. The implementation involves different stakeholders that include the MoHSW and its agencies; development partners; the civil society; community based organisations; professional associations; NGOs; FBOs; voluntary agencies; and the private sector. The Family Planning Working Group was designated to be the coordinator of the entire programme during the six years of its implementation (from 2010 to 2015). The Ministry of Health and Social Welfare was made responsible for the overall coordination and oversight of all aspects of the NFPCIP through developing or updating policies that affect implementation, resource mobilisation and programme monitoring and evaluation.

The planning and budgeting of the health services delivery has been decentralised to the LGA level where the family planning is included in the

Council Comprehensive Health Plan (CCHP). Therefore, the LGAs are playing a critical role in achieving the NFPCIP goals. The development partners (who include the bilateral and multilateral donors) were expected to increase their support to the resources that are required for implementation of NFPCIP. The Civil Society Organisations are not stated to have a specific task to perform, despite the fact that at the time of the conception of the programme (2010), 20% of family planning services were provided by Civil Society against 80% by public health facilities. Moreover, the MoHSW was charged with ensuring coordination, training, procurement of contraceptive commodities, and safeguarding *adherence* by setting services standards and guidelines for civil society organisations and public health facilities. The main sources for the funding of programme implementation were to be from the Tanzanian Government, multilateral and bilateral donors, USAID and fees for services by private-sector providers.

5.11 Monitoring and evaluation

The Family Planning Working Group, development partners and other donors were made responsible for monitoring and evaluation, tracking the achievements of the programme implementation. However, the policy document did not contain a specification of the tools for monitoring the implementation of the strategic activities. The document stated clearly that monitoring and evaluation of plans would be developed later.

In summary, the programme document is well structured, showing clearly the desired goals and the means to realise them. Moreover, the document states clearly that the emphasis would be in two areas: ensuring contraceptive security and strengthening integrated services delivery of family planning in all aspects of healthcare. As such, contraceptive commodities represent 91% of the total NFPCIP budget. Generally, the programme is aiming towards expanded availability and choices of safe, effective, acceptable and affordable contraceptive methods. Furthermore, the programme addresses the capacity of the staff delivering family planning services. Capacity-building consideration comprises of numbers, categories, attitudes, skills, supervision and remuneration of service personnel at all levels and in all health sectors. These efforts will involve:

1. Strengthening of service delivery systems,
2. Increased options for delivery of, affordable, and sustainable family planning services of high quality,
3. Promoting the public dialogue at all levels, national through community, about the important role of family planning in promoting health and gender equity, and
4. Producing monitoring and evaluation of data to improve programme performance.

5.12 Conclusion

The aim of conducting the policy and programme documents analysis was to understand the core qualities of the policy and the programme as conceived and put into the document by the actor of that policy and programme. This analysis was the foundation for the research into the implementation process of policy/programme in regions, LGAs and at health facilities.

The first policy enacted in 1992 was focussing primarily on family planning. Its central goal was to raise the CPR although it did not state to what percentage. The revised policy of 2006 was far more developed than its predecessor, incorporating a wide range of relevant topics including development and stress on reproductive and child health where the family planning is integrated. The 2006 policy lacked clear targets, ways and means for achieving those targets. The NFPCIP was nevertheless clear in explaining the family planning programme and its goal to raise the CPR from 28% to 60% by 2015. It explicitly stated what should be done by whom and when to realise the stated goal.

The next step in this research is the analysis of the implementation of the policies outlined in this chapter. The aim of the reconstruction of the implementation process is to establish whether and to which extent the differences in CPR between regions and LGAs could be attributed to the differences in the implementation of the family planning policies across different regions and LGAs in Tanzania.

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Chapter 6

Implementation at the central government level

6.1 Introduction

The purpose of this chapter is to describe the process of implementation of the family planning programme within the central government.[1] The normal practice in Tanzania is that the policies and programmes are framed by the central government and sent to Local Government Authorities (LGAs) in the form of documents and directives for implementation. The ministry formulates policy and programme documents after which regional offices mobilise and interpret the policies and programmes into actions and provide technical support to the local authorities (National Health Policy 2007). Both the ministry and the region supervise local authorities and oversee the implementation of the family planning programme. This chapter tries to answer three main research questions:

1. What are the documents and directives prepared by the ministry and the regions that are directed to the local authorities?
2. How does the central government disseminate and distribute the prepared documents?
3. What supervision have the ministry and the regions conducted and with what results?

The chapter explores what the ministry and the region did to further the implementation of the family planning programme. It attempts to address three properties of programme implementation *adherence*, *exposure*, and *monitoring and control* as discussed in chapter 3. The chapter begins by scrutinizing the documents prepared by the ministry and discusses the process of dissemination and distribution to the regions and local authorities as well as training process and supervision done by the ministry. It further analyses the documents and directives received by the regions and local authorities. In addition, the chapter examines the plans for programme implementation prepared

1. Under the current administrative set-up in Tanzania, provision of health services is divided into 3 levels, namely, National, Regional and District. The National and regional levels are under Central Government and district under Local Government Authority (National Health Policy 2007).

by the regions, the supervision process, and the feedback received by the implementer. Finally, it discusses the other organisations that play part in the programme implementation process.

6.2 Documents prepared by the ministry

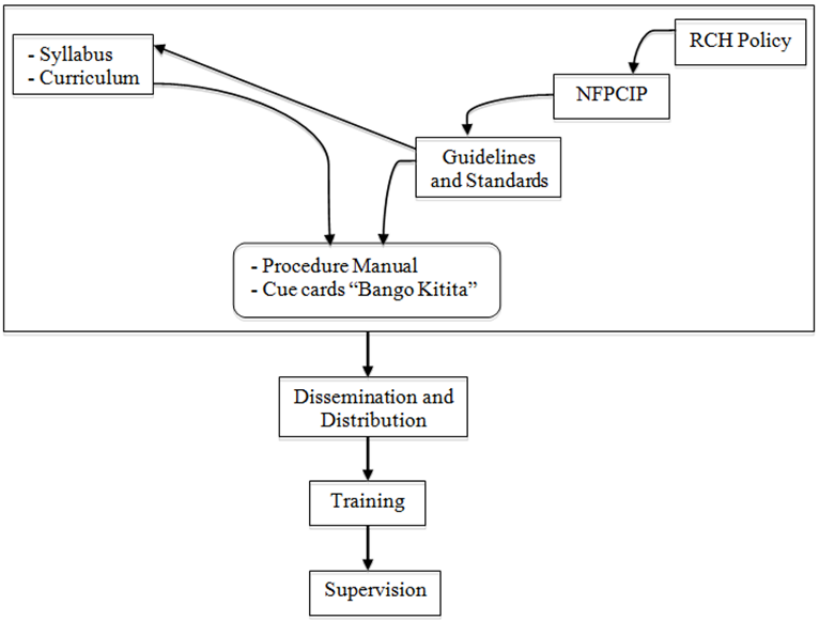
6.2.1 General

In 2010 the Ministry of Health and Social Welfare (MoHSW) in Tanzania saw the need to reposition family planning as the strategy to reduce maternal and child mortality. It developed a strategic document for programme implementation: the *National Family Planning Costed Implementation Programme (NFPCIP)* that was analysed in chapter 5. The NFPCIP specified that its development was '*guided by'* a mother policy: the *Reproductive and Child Health (RCH)* policy of 2003. Moreover, the strategy corresponds with the *National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008–2015 (One Plan)*. The NFPCIP was the mother document in family planning unit that guided the implementation of the programme across the country. The NGOs, regions and LGAs were obliged to use this document.

To foster the implementation process, the ministry[2] prepared different guidelines that intended to foster the family planning programme implementation (figure 6.1). These guidelines included; *National Family Planning Guidelines and Standards; National family planning training curriculum Module I; National family planning training curriculum Module II; The National Family Planning Procedure Manual;* '*Kitendea kazi cha kufanya maamuzi ya huduma ya uzazi wa mpango';* and *National Family Planning Research Agenda*. There was another document that used as a guide for training the trainers called *Basic Training Skills* though the document was not readily available online.

2. The word 'ministry' is used in the following sections to refer the Ministry of Health and Social Welfares Reproductive and Child Health Section (RCH). The RCH was established in 1997 with an overall goal of contributing to improvement of quality of life of Tanzanians with emphasis on gender, equity and women empowerment for sustainable development. Currently, the section consists of the following nine programmes: Family Planning; Safe Motherhood Initiative; Prevention of Mother-to-Child Transmission of HIV (PMTCT); Newborn and Child Health; Immunisation and Vaccine Development; Reproductive Health Cancers; Adolescent Reproductive Health; Gender Based Violence and Violence Against Children; Reproductive and Child Health Commodities; and Management Information System and Research, as a complementary unit.

Figure 6.1: Design of the implementation process at central government



6.2.2 National Family Planning Guidelines and Standards

The document stipulates that it provides explicit directives on (1) Operational rules, regulations and administrative norms governing family planning services and programmes in Tanzania. (2) Minimum acceptable levels of performance and expectations for quality service delivery and programme implementation in Tanzania. This document '*reflects*' the principles and policy guidelines outlined in the *National Policy Guidelines for Reproductive and Child Health Services 2003*: and the priorities and targets identified in the *National Family Planning Costed Implementation Programme (NFPCIP)*. Its intention is to bring uniformity and clarity to guide the implementation of a coherent and coordinated programme.

6.2.3 National family planning training curriculum Module I

The training curriculum model I is the first in a series of three competence-based family planning training modules that provide comprehensive family

planning knowledge and skills to service providers.[3] The family planning training modules are organised as follows:

- Module I: Short-Acting Methods,
- Module II: Long-Acting Methods and
- Module III: Permanent Methods.

According to the introductory part of the module, module I is designed to help trainees acquire skills in family planning services, particularly in the provision of short-acting methods. The model provides comprehensive and essential skills on family planning provision. It is suitable for training aspiring family planning providers. The model stipulates that its content corresponds with the requirements of the national RCH policy guidelines.

6.2.4 National family planning training curriculum Module II

This is the second in a series of three competency-based family planning training modules. This module is intended to help trainees acquire skills in family planning services provision particularly on insertion and removal of IUDs and Implants. It is appropriate for service providers who had already attended the Module I training. Most of the information included in this module is from the WHO's *Family Planning: A Global Handbook for Providers*.

6.2.5 The National Family Planning Procedure Manual

According to the procedure manual, the current manual being the 4th edition, its purpose is to equip family planning service providers with the knowledge and skills required to provide the high quality services to clients. This guideline provides up-to-date knowledge on the current contraceptive methods approved by the MoHSW in Tanzania. The manual has thirteen chapters: each chapter is divided into a number of procedures with specific objectives and materials needed to perform that procedure.

6.2.6 Kitendea kazi cha kufanya maamuzi ya huduma ya uzazi wa mpango

('Tools for provider to make decision during family planning service provision'). This is a set of cue cards (*'Bango Kitita'*) derived from the procedure manual. The cue card is compiled as a reference tool for the procedure to be followed by the providers from the time the client arrives at the family plan-

3. The providers are the Nurse – Midwives who are working in the health facilities undergone a specialisation beyond the normal training to acquire the clinical skills in provision of family planning services. The medical doctors provide the permanent method (Minilap).

ning unit until she leaves. It is required that the cue cards are on the provider's table for quick references during services provision.

6.2.7 National Family Planning Research Agenda (NFPRA)

The family planning research agenda is a document that describes research gaps in knowledge that need to be addressed so as to inform effective and efficient implementation of family planning interventions to reach the country's goal. The intended audiences for the NFPRA include researchers and programme managers in research institutions, academia and civil society, the Ministry of Health and Social Welfare itself, technical agencies, donor agencies and the private sector. The primary objective is to ensure that stakeholders carrying out research in the area of family planning are aware of the country's priority needs for evidence-based information to advance its programme.

All documents accessed acknowledged the contribution of different individuals, national and international organisations as well as different local and international NGOs. All documents except the NFPCIP mentioned the name of the individuals participating in the development of the documents and their affiliation (organisation). The people who were directly involved in actual development of the procedure manual and training curriculums were mainly coming from the reproductive and child health departments of the Ministry of Health and Social Welfare and from NGOs i.e. *Family Health International* (FHI 360), EngenderHealth and Pathfinder International. Few were health providers and RCH 'programme officers'. People from the *National Institute for Medical Research* (NIMR) developed the NFPRA. They were hired as consultant to develop the documents. The document acknowledges the contribution of *Muhimbili Medical Research* and Family Health International in the development of the documents as well. The NFPCIP documents acknowledge that the financial and technical support to develop it was from USAID with technical support from Family Health International. Other organisations that support its development technically were EngenderHealth, John Snow Inc. and Pathfinder International, to mention a few (MoHSW 2010).

In conclusion, all produced documents accredited that they were in line with different national policy and programme documents that govern family planning.

6.3 Documents dissemination and distribution

All the above documents, including the cue cards, are designed to be distributed among the implementers (LGA and health facilities). It is clear that the

procedure manual and cue cards were to be present at every health facility. The guidelines and standards are supposed to be available at local authorities and at all training centres and NGOs. The following section discusses whether the dissemination of all these documents is in accordance with these policy assumptions. As discussed in chapter 3, the policy/programme implementation in general and the dissemination of documents in particular is supposed to follow the system of decentralisation. Thus the ministry should send the documents to the regional offices. The regional offices distribute the documents among the different LGAs in the region and the LGAs spread the same to the health facilities.

A ministry official[4] stated that they had different methods to ensure that the different documents produced reach all regions and LGAs. First the ministry activates the *partners*[5] who participated in the formulation of these programme documents to participate in the dissemination. Second, they organise meetings with the managers[6] to orient them on new updates that were in different documents. The intention was to update documents every three years following their review. EngenderHealth plays a relatively large role in the distribution of these documents produced by the ministry. This NGO has field offices all over the country that acquire the documents and distribute them to their field offices. Subsequently, the field offices disseminate these documents to different regions and LGAs. This is an outline of the dissemination and distribution system of the documents, although a ministry official/P40 did not seem to have a clue to what extent this system worked.

> *'When the NGOs start working in a different region they are disseminating these guidelines during the implementation process because they are implementers.' (*P40: Ministry official)

Dissemination requires the proper quantity of production. In order to be able to distribute into every facility and organisation, it is necessary to have an adequate number of documents produced. The problem that the ministry was experiencing comforted with was the issue of production of the adequate number of programme documents. A ministry official/P40 declared that the ministry did not have the budget to produce enough copies of the prepared documents for the whole country at once. The ministry official could not explain why there was a lack of funds. What was normally done was to re-

4. A ministry official refers to an officer who was interviewed with an identification identity P40.
5. The word partner was used by a ministry official to refer to NGOs, unilateral and multilateral organisations that fund and support family planning activities.
6. The word manager was used in this study to refer to Regional Child Health Coordinators (RCHco), Health Secretaries (HS) and District Reproductive Child Health Coordinators (DRCHco).

quest funds from different donors. However, the ministry did not obtain the funding that would enable the production of a sufficient number of copies.

> *'It depends on the available budget which is always insufficient. Still we try our level best. We may get one donor and help us maybe to produce 20 copies and we find another for other copies in order to have as many copies as we can. But we never had any donor who was able to give us the funds to produce enough copies to cover all implementers.'* (P40: Ministry Official)

In summary, the documents produced were not enough to cover all organisations involved in family planning programme implementation. The documents dissemination and distribution did not follow the hierarchical structure only: the ministry used other organisations (NGOs) too.

6.4 Training

During the interview with P40 it was noted that the ministry coordinated all training conducted by different *Zonal Health Resource Centres (ZHRC)* and NGOs. The intention was to make sure that implementers were using the guidelines that were prepared by the ministry. However, the ministry was said to lack the staff to monitor every training. A ministry official/P40 declared that they did not have enough staff to attend all training sessions being conducted to ensure the trainer delivers the training as designed. To address the perceived problem of staff shortages, the ministry limited their attendance to few training sessions. These trainings included training other trainers who in turn train the service providers in different parts of Tanzania. This is discussed more extensively in chapter 7.

> *'All trainers use the national documents and during training they invite someone from the ministry to oversee. Unfortunately, we are very few at the ministerial level, so we just give them our blessing because we know more or less how they conduct the training process. But sometimes we sample a few trainings and go to see what is done.'* (P40: Ministry Official)

6.5 Documents and directives received by regions and local authorities

In order to ascertain whether the documents prepared by the ministry reached the implementers, the RCHco were asked about the documents received from the ministry. They responded that their region received *'different policies and guidelines from the ministry. The regional offices redistribute these docu-*

ments to local authorities which were then distributed to the health facilities.' Yet the RCHcos were not able to specify the document(s) they had received.

Similarly, at the local level, the DRCHco just responded, '*we received different documents from above'* but were unable to say if the documents came from the ministry or from the region. A majority of the DRCHco's declared, after more probing, that most of the guidelines and programme updates were received during training sessions. They got them in the form of a training manual when an NGO or ZHRC conducted training in their area, or when they were invited to attend training in other places. This corroborates the finding that the ministry did not produce enough copies of documents. Receiving the documents in the course of a training concurs with the findings above which show that EngenderHealth played a large role in disseminating and distributing the programme documents.

> *'For now we get these documents from training as a training manual, when they come for training they come with them or if a person goes for training it comes back with them.'* (P22: DRCHco)

The providers were asked about the directives and documents received from the LGAs' offices. The providers responded that they indeed received updates. However, when asked about the types of the updates they had received, only one provider (from Moshi DC) mentioned that she was told about one item: a new way of calculating the '*Couple Year Protection*' (CYP). Furthermore, the provider declared that the LGA only communicated with them when there were mistakes in the monthly report that had been submitted to the LGA office. Others said that they only communicated with an LGA when they had a shortage of family planning drugs.

> *'Last week she told me how to make sure that I have realised my objectives. There is one thing called the 'family planning indicator'. It is measured by a tool called CYP where C stand for couple, Y for year and P for protection. So she told me these indicators are as follow, Bilateral Tubal Ligation (BTL) scores 8, IUD scores 3.5, Injection scores 0.5 and pills 0.2. This means if in your facility you encourage the clients to use more short acting methods than long acting methods your indicator will be low. Therefore, you cannot protect the couple as required, so you should stress more on long acting methods and permanent methods. That is why most of my clients are those who use the long acting methods.'* (P27: Health Provider)

In general, only five out of eight facilities studied were witnessed displaying the cue cards '*Bango Kitita*' on their tables: four from Kilimanjaro and one from Mara during fieldwork. It was unclear whether the three deficient facilities from Mara did not have the cue cards or did not use them. Moreover,

only two facilities from Kilimanjaro had the family planning procedure manual (2012) document. Other providers declared that the LGA office only sent them the clients' cards and the books to report the different family planning services provided.

6.6 Supervision processes done by the ministry and the region

Monitoring and evaluation (M&E) involves collecting different data from the programme implementation process. The data are then analysed to inform the supervisor. The supervisor then decides how to address observed shortfalls.

The most striking result that emerged from the interviews (P40) was that the ministry did not have an M&E expert. An expert from an NGO conducted the M&E activities. A ministry official (P40) said that the M&E activities were moving along fine. However, because they were done by an external organisation, she felt the ministry was losing ownership of the programme. The ministry was entirely dependant on so called *'partners'* to conduct the M&E. The person who performed the M&E was assigned by USAID to monitor the NFPCIP. This person was a member of the Family Planning Technical Group working at Family Health International (FHI 360).

> *'In the area of M&E I can say this department is weak. We as ministry do not have an M&E expert: as you see me here I am everything. I am tired. I never attended any course on M&E. I am the one who enters the data in the system and the M&E expert in the Family Planning Technical Group (secretariat) from the NGO helps me in the analysis. It does not make sense for the data to be analysed by another person. So for me I am not comfortable despite the fact that everything is moving fine.' (*P40: Ministry Official)

The M&E report is supposed to inform the manager on whether programme goals are being achieved and to what extent there is need for mid-course correction to address emerging problems. This involves committing more resources or even changes in some of the plans to address an observed shortfall. A ministry official (P40) declared that the ministry prepares quarterly M&E reports that help them to reallocate the different *partners* to strategic areas that had few NGOs. They even reallocated them to other regions and other LGAs where there were too few NGOs that supported the implementation of the programme.

> *'He produces the M&E reports quarterly. The reports help us a lot. For instance, after looking on the report we realise there are some regions that do not have partners or there are regions that have patches of partners that just work only in one council and leave other councils. So we start doing mapping telling them to move from*

> *that council and go to this council, or this strategic area does not have enough partners shifts from that and go to this strategy.'* **(**P40: Ministry Official)

Furthermore, monitoring and control of the process of service provision is believed to be a critical part of human resource management. The programme managers acknowledged that supervision was an important aspect that spurred implementers and got things done. As said by one DRCHco:

> *'You know when you are working and someone comes for supervision you wake up. But if you are working alone you do not know if you are right or wrong and you know we already have a tradition of been monitored.'* (P23: DRCHco)

Knowing the number of inspections conducted allows the researcher to determine the amount (*dosage)* of this part of the programme implemented in relation to what is stipulated in the Guidelines. The information given by respondent *P40* indicates that the ministry is required to conduct at least one inspection per year in each of the eight zones in Tanzania. However, during the year 2014 the ministry had managed to conduct only four inspections. This comprises four regions out of twenty five regions in Tanzania mainland. She said that:

> *'During last year we went four times for an inspection. Geita, Simiyu. Last year we did the best because we did as recommended. We supervised four regions, but in the guideline it is required to go to different zones and at least visit every zone once. We have eight zones; we are required at least in a year to pass all zones. During last year we visited two zones, which means four regions.'* (P40: Ministry official)

Conclusion, there was hardly any supervision *(monitoring and control)* done by the ministry.

6.7 Regional programme implementation process

So far this chapter has focussed on family planning programme implementation by the ministry. As pointed out in the introduction to this chapter, the region is concerned with transforming the programme documents into actions. Thus, the regional managers were asked about their plans and targets for family planning programme implementation. Moreover, the DRCHco were asked about their perception of the supervision conducted by the ministry and the regions.

All interviewed RCHco's failed to tell what their regional plans and targets were and what they aspired as a region to realise as far as family planning was concerned. What they often mentioned was the number of clients served. This was one of the programme outputs that was documented in their monthly and quarterly reports received from different LGAs.

Further the RCHco's said that, if the ministry conducts an inspection of local family planning activities in the region, this was done as part of an overall supervision of the activities of the health centres concerning with reproductive and child health. The RCHco's emphasised that the ministry merely wanted to know the way the services were delivered to clients and whether the providers followed the procedures and guidelines. The NGOs that conducted the training also conducted an evaluation to establish whether the health workers who attended the training had indeed applied what they were supposed to have learned during the training. This was acknowledged by one of RCHco's.

> *'Our stakeholders who conduct training do supervision after training. The aim is to check if what they had taught is being applied as it was taught. If they find problems or if the providers are not doing as they were taught the stakeholders may train the providers again.'* (P36: RCHco)

During the interviews, the regional officers refused to discuss the amount of supervision done within the region. When asked how many times they conducted supervision over the past year (2014) all of them replicated what was expected to be done according to the guideline i.e. conducting supervision quarterly. During the interview some regional health secretaries show the supervision reports. The supervision report indicated that the region conducted supervision after four months and the supervision was done in few LGAs across the region.

The regional health secretaries mentioned the timely disbursement of funds from central government as one of the obstacles that hindered the regions in conducting all supervisions as required in the guidelines. The obstacle was, according to health secretaries, that the central government disbursed the funds far too late. The supervision process needs these financial resources for car fuel and for allowances for the team that would be involved in supervision. Hence, if the regional office did not have the funds it was not possible for them to conduct the supervision as required.

> *'First we have the challenges of receiving the funding. At least this year I have seen the funds come early. We received the funds for the first quarter in October even though the first quarter had already passed. It starts from July and ends on September. How would you conduct supervision while you need fuel for cars and subsistence allowances?'* (P39: Regional Health Secretary)

In order to explore more about the supervision done by the ministry and the regions, DRCHco's and providers were asked about their experiences. All DRCHco's indicated that the ministry officials start a supervision trip at the regional offices, then move to the LGA offices and then end up at the facility level. Such supervisions were, however, seldom done. Most of the time supervision was conducted by NGOs that also provided the family planning services. The few times inspections were conducted, the supervisors were interested in how the services were delivered to clients, assessing if the providers followed the procedures and whether the different guidelines were present at the facilities. During supervision the supervisors from the ministry '*used polite language and were humble'*. The supervisors were humble because they were well aware of course that the ministry itself caused many of the obstacles impeding the provision of family planning services.

> *'Those from the ministry - when they come they start from the regional office. After that the one who is concerned with that supervision, the RCH coordinator, communicates with the DMO that we will have supervision from the ministry. For instance, when they come they observe how the provider inserts the IUD; they look if that procedure is been performed as required. They also observe available equipment as per recommended and the availability of staff. I should say the supervisor from the ministry always observes the performance and procedure. Nowadays they use good language. I see they are not so strict because most of the challenges facing the facilities and councils as whole are caused by the ministry.'* (P23: DRCHco)

The DRCHco at Kilimanjaro LGAs said that it was very rare to have supervision from the region and the ministry. During the foregoing year (2014), they had not seen them at all. Previously the regional offices used to have a cooperative relationship with the LGAs offices; they were even conducting supervision together. Lately, however, no representatives from the region showed up. The DRCHco from Mara LGAs' reported the same experiences.

Musoma MC managers said that formally the ministry officials were supposed to inspect the LGA twice a year. Yet they could not tell how many times the supervisors from the ministry and region visited the LGA during the year when this study was conducted. The DRCHco from Mara region had a similar comment: he thought that the supervisors from the region were not really conducting supervision since they hardly ever visited despite being so close to them.

> *'Region…Mmmh! The region I can say does not conduct supervision because they may stay away for a year or more. Now because they are very*

close to us we expect them to come frequently, even every three months but they may stay away for six months or one year. I don't consider this is supervision because a region should not wait so long to come for supervision, especially because they are so close.' (P23: DRCHco)

In summary, the same supervision trends[7] noted at the ministry level prevailed at the regional level. The collected evidence shows that the regions did very few inspection sessions.

6.8 Feedback received

The regions received monthly reports from the LGAs on contraceptives utilisations and on the availability of contraceptives that they in turn submitted to the ministry. These reports indicated problems encountered during programme implementation as well. The regions generally did not receive any feedback from the ministry after submitting such reports pertaining to family planning. They only received feedback when a report contained issues that needed clarification or a solution, but even then feedback was very rare. The RCHco of each of the regions Kilimanjaro and Mara reported this.

> *'You know when we write the reports there are some areas, which we work on them and other which we send to the ministry for them to work on. During implementation they may work on them but they do not tell the region we have seen this and we are working on it.'* (P36: RCHco)

The DRCHco's of the LGA's commented in the same way. One of the things they recounted in the monthly report was the availability of family planning drugs. They rarely got feedback from regional and the ministry offices when they reported shortages of contraceptives. To resolve the problem of contraceptive shortages, they met with people from Medical Store Department (MSD) and the NGOs. The regional and the ministry officials were not involved.

7. Generally, the ministry and region were doing in person, to visit LGAs and providers to inform themselves of the local policies and observe the practice of service delivery in the health centres. Likewise, the LGAs did the same as ministry and region visiting health facilities with additional supervision. At the LGAs the DRCHcos scrutinizing reports from health facilities; if the reports contain a detailed account of the practices and take notice of these reports, then after uploading into District Health Information Software (DHIS2) where the region, the ministry and NGOs that have access see the reports.

6.9 Other organisations that play part in programme implementation process

The final section of this chapter addresses the second pillar of central government programme implementation. So far, the chapter discussed the intergovernmental implementation process. However, there was additional implementation taking place between the ministry, the *development partners*[8] and the NGOs that provided family planning services. To structure the implementation process, the ministry set up the Family Planning Technical Working Group (FP TWG) (see box 1). According to a ministry official interviewed the FP TWG was responsible for coordinating all family planning programme activities as stipulated in the National Family Planning Costed Implementation Programme (NFPCIP) document. All partners involved in the provision of family planning services were required to send their monthly plans to the ministry. Subsequently, the ministry compiled these plans and prepared a national monthly work plan. Thus, the ministry would know which NGOs were providing what family planning services or conducting what training, when and where. Accordingly, the ministry was supposedly in control of all NGO activities. Concerning training activities for instance, the ministry was to identify the name of the trainers who facilitated these training. In practice however, the ministry allowed the NGOs to identify the trainers themselves while the ministry just confirmed their choice. The trainers were government employees working in different health facilities. They had been trained by the same NGOs that selected them to be trainers. The NGOs would then request the ministry to release these health workers from their common duties so they could be trainers.

Box 1: Family Planning Technical Working Group
The Family Planning Technical Working Group (FP TWG) was charged with monitoring and evaluating the implementation of national policies and plans related to the provision of family planning services and coordination of all groups involved in provision of the family planning. Membership of the working group included government officials, donor representatives, the private sector and both local and international NGOs. The FP TWG has government support and authorisation to work in a technical coordination role. It has the authority to respond to issues or concerns: it guides the government and provides advice on family planning topics, after which the government indicates approval and takes action. The chair is the National Family Planning Technical Coordinator, who reports to the Assistant Director of Preventive Services (also the Director of the Reproductive and Child Health Section), who reports to the Director of Preventive Services, who reports to the Chief Medical Officer, who reports to the Minister of Health (Judice 2013).

8. These are NGOs, bilateral and multilateral organisations that finance family planning programmes.

The ministry has divided the country into eight *Zonal Health Resource Centres (ZHRC)*. Each of these resource centres conducts a different kind of training in the health field, including family planning. The ZHRCs are managed by public officials and are responsible for the provision of training on short acting methods for public health facilities. Yet there were also NGOs providing training for family planning services in Tanzania. Those NGOs were PSI, Maria Stopes and EngenderHealth. PSI conducted training on short acting methods in private health facilities. Maria Stopes and EngenderHealth provided training on long acting methods as well as provision of long acting methods: IUD, implants and permanent methods (*for more information see box 2)*. According to a ministry official (P40) all ZHRCs and NGOs were getting support from USAID. The guidelines authorised by the ministry apply to all training conducted and services provided by these NGOs. A ministry official (P40) said that the ministry made an attempt to coordinate all NGOs that were engaged in family planning activities making sure that there was an equal distribution of NGOs across five strategic areas in NFPCIP and across all regions.

One of the ministry officials interviewed said that the availability of funds was a major challenge for the implementation of the family planning programme. Lack of funds had caused shortages of family planning commodities in previous years (2010 to 2013). Different organisations such as the Tanzanian government and bilateral and multilateral organisations, were involved in the purchasing of family planning drugs (commodities) In the words of a ministry official (P40):

> *'Currently, the government is contributing; DFID (Department for International Development), UNFPA (United Nations Population Fund), USAID and other partners contribute a lot to purchase the family planning drugs. For instance, Depo Provera and Implanon were purchased by the government; pills and IUD purchased by USAID and DFID has provided a lot of funds to purchases the contraceptives.'* (P40: Ministry official)

Box 2: NGOs/Organisation working in family planning
Zonal Health Resource Centres: The MoHSW established the eight ZHRCs (formerly known as Zonal Training Centres). The aim was to facilitate the updating of health care workers' skills and to monitor the Health Training Institutions in their respective catchment areas. These zones are, Northern Zone - Centre for Educational Development in Health, Arusha (CEDHA); Southern Highland Zone - Primary Health Care Institute (PHCI) in Iringa; Western Zone - Clinical Officers Training Centre (COTC) in Kigoma; Eastern Zone - Public Health Nursing School 'A' (PHN 'A') in Morogoro; Southern Zone - COTC in Mtwara; Lake Zone - Assistant Medical Officers (AMOs) Training Centre in Mwanza; South-West Highlands Zonal Health Resource Center in Mbeya; and Central Zonal Health Resource Center in Dodoma.
Marie Stopes Tanzania is an NGO that started its operation in Tanzania since 1989. They provide a range of integrated sexual and reproductive health services including: family planning, health screening, maternal health, post abortion care, cervical cancer screening and primary healthcare. Their focus is predominantly on hard to reach rural locations and urban slums, with services provided by their clinical outreach teams. Though, they have 12 clinics; one hospital in Dar es Salaam and 11 dispensaries that are located in urban areas at Dar es Salaam, the Lake zone, Northern zone, and Zanzibar: rather than rural area and slums.
EngenderHealth is an NGO that has a partnership with the MoHSW: it works in Tanzania nationwide on family planning (FP), gender issues, FP-HIV integration, and other health initiatives. EngenderHealth and the MoHSW work together to promote access and facilitate the use of family planning at the facility level. They also organise special FP days and mobile outreach services to access hard-to-reach communities.
Population Services International (PSI) Tanzania is a not-for-profit Tanzanian trust organisation that has been working to improve the health of Tanzanians since 1993. They use social marketing to engage private sector resources and use private sector techniques to encourage healthy behaviour. They intend to 'make markets work for the poor'. PSI is affiliated with an international social marketing organisation that is working in over 60 countries and that is based in Washington DC.

Sources: Extracted from the NGOs' website home page August 2015.

6.10 Concluding remarks

Returning to the questions posed at the beginning of this chapter, it is now possible to formulate the following answers. The central government prepared different documents as guides for the implementation of family planning programmes. It used different strategies to disseminate and distribute the produced documents. It conducted very little supervision in the areas under study. An expert wrote the different family planning documents but the ministry was to take care of the authorisation. NGOs organised most of the training sessions under approval of the ministry. The ministry did not actively participate in the dissemination and distribution of produced documents. The reason given was, that a lack of funds precluded the production of enough copies.

Regarding *adherence,* the study assessed the extent to which family planning guidelines and standards, training curriculum, procedure manual documents and cue cards are adequately adhering with strategic documents, NFPCIP, and the mother policy (*Reproductive and Child Health policy*). All produced documents acknowledged that they were in line with the requirements of the strategic and policy documents. From our own analysis we concluded that the documents produced to implement the programme *adhere* to strategic and policy documents.

The *exposure/dosage* was inadequate because the distribution of the different documents was limited. The evidence collected shows that the regions were not exposed to the implementation documents produced by the ministry. Consequently, the regions did not share these documents with the LGAs. A more detailed picture of the *exposure* within the LGAs is presented in the next chapters. The main question to be answered is whether the LGAs provided health centres with the relevant documents.

The M&E activities were carried out by other organisations rather than by the ministry. This caused ministry officials to lose their sense of programme ownership. The ministry managed to conduct only four inspections in two zones covering four regions out of twenty five regions. The ministry and region are doing only one type of supervision, actual going to the place of services delivery and inspect whether the provider follows the procedure and guideline during services delivery. Whilst the LGAs visit the facilities and scrutinise the report produced by the health facilities. This was very low compared to what is recommended by the Guidelines. From the evidence collected we can conclude that the regions were rarely conducting any supervisions *(monitoring and control).*

In conclusion, the implementation by the central government showed a high level of *adherence*, a low level of *exposure* and a low level of *monitoring and control*.

Chapter 7

Implementation at the local authority level

7.1 Introduction

The Local Government Authorities (LGAs) have the task of providing health services at the local level. Thus, the LGA is responsible for the district hospital, the health centres and the dispensaries (National Health Policy 2007). The health services at the LGA are subordinate to the health department that is headed by the District Medical Officer (DMO[1]). Reproductive and Child Health (RCH) is one of the sections in the DMO's office. The section is required by the central government's health policy to formulate an action plan for implementing the RCH services, including a family planning programme. Furthermore, it is the duty of department to conduct supervision, programme advocacy, and to provide technical support to the street level implementers. Lastly, the department is required to strive for community sensitisation through health education and outreach services.

The aim of this chapter is to reconstruct family planning programme implementation by the LGAs. The reconstruction explores the plans, targets and strategies formulated by these LGAs to implement the family planning programme. More specifically, the following elements of implementation will be discussed: training, drugs ordering and supervision; community outreach services; awareness and community acceptance; other organisations that provide family planning in the LGA and challenges perceived by managers and providers. The aim was to address three properties of programme implementation: adherence, exposure and monitoring and control, as discussed in chapter 3. Three key questions to be answered in this chapter were formulated:

1. What are the plans, targets and strategies formulated by the LGAs concerning the implementation of the family planning programme?
2. How do LGAs organise the training of the providers, the ordering of drugs, the conduct of supervision and community outreach services?
3. Do LGAs show relevant programme differences in:

1. The DMO is appointed by the Permanent Secretary of the Prime Minister's Office Regional Administration and Local Government (PMO-RALG), though s/he is subordinate to the Executive Director.

i. Community awareness and acceptance;
ii. The presence (number and quality) of other institutions that provide family planning and
iii. Perceived working challenges?

7.2 Plans, targets and strategies for programme implementation prepared

7.2.1 General

In theory, DMOs have the responsibility for planning, coordinating and implementing different national health policies and programmes, taking into account the LGA's priorities. This includes supervising all aspects of health services delivered at religious health facilities, private health facilities and drug outlets (Musau 2011). DMOs are required by the policy guidelines to identify the LGA priorities and to plan how the resources are to be allocated and spent to address local health wants (Chitama et al. 2011). The DMO is supported by the Council Health Management Team (CHMT[2]).

7.2.2 Plans

The Comprehensive Council Health Plan (CCHP) is the annual health plan for an LGA. It is supposed to contain the health and social welfare plans: objectives, strategies, interventions, activities to address health priorities and indicators to measure progress/performance. Its preparation encompasses different people and organisations that identify LGA health priorities. To begin with, the CHMT collects the plans prepared by the district hospital, health centres, dispensaries, RCH section and other sections to be included in the CCHP. Thereafter, the Council Health Planning Team (CHPT[3]) deliberates and approves these priorities to assure the coordinated delivery of the health services at the LGA. Then the preparation of the CCHP document of an LGA passes through different stages before being submitted to the Ministry of Health and Social Welfare (MoHSW) and the Prime Minister's Office

2. CHMT Consist of: District Medical Officer; District Nursing Officer; District Health Officer; District Health Secretary; District Pharmacist; District Medical Laboratory Technologist and District Dental Surgeon.
3. Composition of the CHPT team: District Medical Officer (Chairperson); District Health Secretary (Secretary); District Planning Officer (Technical Advisor); All CHMT Members and Co-opted members District Cold Chain Coordinator; District Reproductive and Child Health Coordinator; District Tuberculosis and Leprosy Coordinator; District Aids Control Coordinator; Malaria Focal Person; Health Management Information System; School Health and Neglected Tropical Disease Coordinators. Moreover, the Medical Officer Incharge; district health accountant; representative from the private sector; representative from NGOs; representative from community development department; representative of faith based service providers (religious organisations, voluntary agencies) and representative of the Regional Health Management team (RHMT).

Regional Administration and Local Government (PMO-RALG) for assessment, approval and funding. After the CHPT meeting the health secretary prepares the CCHP document which is checked by the council treasury and authorised by the DMO. Further, the Council Health Board (CHSB[4]) approves the document. Then it is sent to the Regional Secretariat where it is scrutinised for correspondence with the guidelines. Lastly, it passes the full council meeting, the highest political decision body in the LGA, for deliberation and final approval. After approval the CCHP document is forwarded to the MoHSW and PMO-RALG (Chitama et al. 2011).

So far the chapter has discussed the general planning procedures. The following sections will set forth to which extent these procedures could be found implemented in the LGAs' under study. Of the four LGAs studied, two LGAs, Moshi DC and Musoma DC, have included family planning in their CCHP (2013/2014) as the area of intervention that addresses the problem of low CPR. Musoma MC, however, did not mention family planning as intervention area; instead the plan contained the statement that the LGA was faced with a *'low percentage of new attendance for family planning at the six health facilities'*. The Moshi MC CCHP did not mention anything on family planning. With one exception, the LGA managers[5] and the providers were not able to tell if their LGAs had any implementation programming concerning family planning provision. Only the DRCHco from Musoma DC said that, *'we have a plan to make sure that in every facility we have someone who knows how to provide services in all methods'*. The evidence collected through interviews shows that the managers at Musoma DC were already aware that they are the LGA with the lowest CPR in the country according to Tanzania Demographic and Health Survey (2010).

7.2.3 Targets

To realise the programme's objectives, the targets and the desired amount of intervention have to be defined by the number and quality of activities that have to be carried out. Apart from sections on priorities, problems and interventions, the CCHP has to contain a section in which targets are stated: see the figure 'table 3' that was extracted from the Comprehensive Council Health Planning Guidelines (2011).

4. Composition of CHSB: four health service users out of the communities (at least two women); the representative from non-profit voluntary agency; the representative from private-for-profit health care agency; the Chairperson of the Council Social Service Committee; the Council Planning Officer; the District Medical Officer (DMO), who is the Secretary to the Board; one representative from the hospital and one representative from Regional Health Management Team.
5. Manager in this chapter refers to the District Reproductive and Child Health Coordinators (DRCHco) and Council Health Secretary.

Table 3: Formulating Objectives, Targets and Activities
Council……..

Priority Area (EHP)	Area of intervention (EHP)	Problem	Objectives (Code & description)	Target: (Code Description)	Activity (code & description)	Cost Centre	Source of funds
1	2	3	4	5	6	7	
Maternal Newborn and Child Health	New born care	High under 5 children mortality rate.	**C:** Improve access , quality and equitable social services	**01S:** Under 5 years mortality rate reduced from 109/1,000	**C01S01:** To procure baby resuscitation supplies and		

None of the four LGAs specified any target(s) for family planning in their CCHP documents 2013/2014. However, the Comprehensive Council Health Planning Guidelines (2011) state that the target was to increase the CPR from 20% to 60% by 2015 nationwide. These findings about the CCHP of the four councils were substantiated with information given by most of the respondents: neither the DRCHco, the Health Secretaries, nor the providers were able to tell what plans and targets the LGAs and the facilities aspired to realise as far as family planning was concerned.

The DRCHco and the providers did not even know their current CPR and their new targets. For instance: one DRCHco said that the aim was to reach 60% CPR by 2015 (which is the national target) without knowing that her region already reached 65% since 2010 and that the new target, according to the national family planning programme document (NFPCIP), was to reach 74%.

The same reaction was given by providers from different facilities and LGAs. Most of them declared that they did not know of any plan or targets; what they were doing was just providing family planning services. The providers emphasised that they had never attended any relevant training, so they did not know how to set targets. Yet some of them said that their work in the unit had motivated and encouraged them to start thinking about setting targets. There was one exception to the general picture: the provider from Musoma DC declared that her facility had clearly stipulated targets to be realised. The Medical Officer in-charge monitored the progress in attaining the targets through discussions with the providers.

> *'After the general clinical meeting the doctor in-charge regularly came in our unit and asked us: 'what are your targets, have you realised them, what obstacles did you encounter?' So we explained: 'for this year our target is to serve 889 clients. I do not know if we will realise our target but we already reached 764 clients.'* (P30: Health Provider)

In some of the other LGAs the presence of the researcher created some awareness with the LGAs' manager and providers about target setting during

the annual planning cycle. They declared that the interview questions were a wake-up call for them and promised the researcher to start setting the plan and targets to be realised as from the next year. One participant reported:

> *'You have given me a challenge. The day before yesterday we were working on council's annual planning with the DRCHco who is a member of the planning team (CHPT). I was telling her that: 'so far in your section we only have the target to reduce maternal and child death from certain number to a certain number. But we do not have any targets to scale up the family planning from may be 200 to 500 clients.' After this discussion (interview) we might think on how to include the family planning targets in next year's planning.'* (P35: Health Secretary)

7.2.4 Strategies used to realise the targets

Another aspect that needs to be addressed in the CCHP is the activities to be done in order to realise the stated targets. Two of the four councils, Moshi DC and Musoma DC, had a CCHP stipulating activities to address the existing family planning problems. The Moshi DC activity was, *'to conduct 3 days advocacy on family planning to 30 village health providers by 2014'*. Musoma DC stipulated, '*to conduct quarterly mobile health services on family planning to six villages without health facilities by June 2014*'.

Even though it was not written in their CCHP's, the DRCHco's from all studied LGAs showed that they had somewhat of a strategy to implement the family planning programme. Some said that they would continue to request the support from NGOs to provide family planning assistance in their areas. Three LGAs used a strategy of integrating family planning services and other services such as the Care and Treatment Clinic (CTC) services, in order to increase the acceptance rates. More specifically, Moshi DC managers declared that they would continue using the Community Based Distributors (CBD) to provide education on family planning in any area where there was a gathering of people such as markets and village assembly.

Musoma DC learned that it was the LGA with the lowest CPR and decided to undertake a campaign with the regional office and a number of NGO's as strategy to address the problem. They conducted a lot of outreach services to provide family planning services in the areas where they did not have health facilities. This was accompanied by health education activities in villages, explaining the advantages of using family planning. They managed to visit all 61 villages in the LGA over the previous two years (2012/2013, 2013/2014).

The health facilities that were identified as training centres had more family planning users than the facilities that were not used as training centres. The reason is, that the students who were trained actively recruited clients for their practical sessions, rather than limit themselves to the clients who volun-

tarily visited the health facilities for family planning services. The students convinced patients who were elsewhere in the health facility to join family planning services, and this increased the number of family planning users. This was done in two facilities at Moshi MC and one facility at Musoma MC.

Only one facility (from Musoma DC) had community outreach services as a strategy to realise its targets. As reported by the provider:

> *'We are not providing services only in this facility. Sometimes we go for outreach and provide the services in nearby villages. For instance, when we have a car we plan may be on Wednesday to go to certain villages, which are far from this facility. The car picks up the staff that are trained on family planning and go to provide outreach services.'* (P30: Health Provider)

Table 7.1 contains a summation of the previous findings in a comparative perspective. It shows that the area of intervention, the stipulation of the problem associated with family planning and the strategies to address the problem are areas in which LGAs differ. There is no difference between LGAs as far as target setting is concerned: none of the LGAs has any written targets. Musoma DC did better than the rest of LGAs in preparing for implementation, while Moshi MC did not stipulate anything in its CCHP concerning family planning.

This result may be explained by the fact that before 1998 the family planning programme in Tanzania was a vertical[6] programme that followed the hierarchical structure. It was a stand-alone programme coordinated by the Ministry of Health and Social Welfare and NGOs such as UMATI, getting support from bilateral and multilateral organisations.[7] Later on, the programme was integrated into RCH services, leaving the ministry with the role of facilitating the health services and providing policies and leadership (Pile and Simbakalia 2006). The major thrust of changing from a hierarchical to an intergovernmental relationship between central government and local gov-

6. A vertical programme is usually supported by separate staffing and has a different logistics. Even where services are integrated at the LGA level and below, there are still separate management, supervision, reporting and support structures above that support programme delivery. Vertical programmes are of necessity top down in design and implementation, whereas decentralisation emphasises that all health planning is to be done by the LGA and that it is to include all services in existing institutional arrangements for service delivery.
7. Bilateral organisation refers to organisation that provides assistance directly to a recipient country. The donor organisation (government) provides the assistance directly to the recipient government or to non-governmental institutions operating in the recipient country. This support is sometimes managed by a government agency charged with this task. Multilateral organisation involves more than two parties. The donor country or organisation sends funds to these multilateral organisations such as the World Bank (WB), The United Nations Population Fund (UNFPA) and the United Nations (UN), which in turn administer the donations to several recipient countries.

ernments was that the programme be controlled by the LGAs. Yet the evidence shows that the ministry still has a lot of control over the programme. As explained in section one of this chapter the LGAs plan have to pass through different phases of scrutiny by central government officials in order to be accepted for financing. This is one of many indications that the decentralisation by devolution is largely just on paper; while in reality the central government and its regional branch do control the local plans (Mollel 2010). LGAs preference to abide with hierarchical structure might be one explanation why the central government accept local plans without a family planning section knowing they will get them separately.

The way family planning is structured the administrative functions are spread out over four levels: ministry, region, local authorities and health facilities. This structure caused some of the local authorities to prefer the hierarchical system over self-reliance. These LGAs opted to communicate all activities related to programme to higher levels: the region and the ministry. Consequently, they failed to integrate the programme into the LGA's plans - as was observed in the Moshi municipal council.

Table 7.1: Plans, targets and strategy for programme implementation prepared

Indicators	**Moshi MC**	**Moshi DC**	**Musoma MC**	**Musoma DC**
Area of Intervention/Plan	-	+	-	+
Problem	-	-	+	+
Target	-	-	-	-
Activity/Strategy	-	+	-	+
Adherence[8] with 4 items	Lowest	High	Low	Highest

Note: the symbol '+' indicates that Family Planning (FP) was mentioned in this category at CCHP while the symbol '-' indicates that FP was not mentioned in this category.

7.3 Training

7.3.1 General

The main benefit for the providers in attending training is to acquire the skills to organise Reproductive and Child Health (RCH) clinics and to offer quality family planning and other RCH services. More specifically, the provider attains the abilities:

8. The adherence ranking was obtained by dividing the possible score that is 4 by 4 LGAs to get the interval. Then the ranking was grouped into four categories i.e highest, high, low and lowest.

- To counsel, screen clients and provide short acting and long acting family planning (FP) methods of their choice,
- To counsel clients on other contraceptive-related problems and other RCH needs and
- Maintain and use FP/RCH records to improve services.

7.3.2 Organisations that conduct training

As noted in chapter 6, most of the training was carried out by private non-governmental organisations. One NGO, EngenderHealth and one institution, the Centre for Educational Development in Health (CEDHA[9]), conducted most of the training in the LGAs under study. CEDHA conducts training on short acting methods. EngenderHealth mostly conducts training for long acting methods and only occasionally on short acting method. Moreover, EngenderHealth is actively involved in the provision of long acting methods and permanent methods (Minilap). The ministry itself was using its employees to conduct some of the training whenever there were funds available. The LGAs did not have funds to organise any training because as from 2012 the MoHSW instructed the LGAs to remove training activities from their health plans. The reason behind this instruction to remove the training from LGA plan is not clear.

As the tables 7.2 and 7.3 show, there is a significant difference between LGAs and facilities concerning the number of providers trained and concerning the organiser of the training. Three organisations (EngenderHealth, CEDHA and MoHSW) conducted the training sessions at Moshi municipal council, though formally the MoHSW was the main trainer. At Moshi DC two organisations (EngenderHealth and CEDHA) provided the training. The main trainer was EngenderHealth. As a result, Moshi district had more providers who were trained to provide long-acting methods than the other LGAs under study. Musoma MC had fewer providers who were trained compared to the other LGAs, even though it staff received training from all three organisations. EngenderHealth and MoHSW conducted the training at Musoma DC, while the main trainer was the MoHSW. Generally, EngenderHealth conducted its share of the training in all four LGAs, while CEDHA and MoHSW conducted training in three LGAs only.

From the data in table 7.3, it is apparent that three health facilities out of four in Musoma MC and Musoma DC had staff who were trained to provide

9. (CEDHA) - Arusha is one of eight Zonal Health Resource Centres in the Northern zone. Additionally, it is a professional institute under the Directorate of Human Resources Development of the Ministry of Health and Social Welfare in the United Republic of Tanzania. CEDHA is a semi-autonomous institution established in 1983. The aim of CEDHA is to strengthen and support the health care system through training of human resources for health in health personnel education, health services management and continuous professional development.

both short acting methods and long acting methods. Yet, the staff allocated to the family planning units were trained on short acting methods only. There was strong evidence that the providers who were trained in both methods were located in other units rather than in family planning. One of the DRCH-co explained this state of affairs as follows:

> *'Another problem is that we do not have enough staff to be stationed in the family planning unit for more than three months. The available staff rotates in other units in the health facilities as well. In general I can say we have a shortage of staff.'* (P24: DRCHco)

Table 7.3: Number of provider trained on short-term and Long-term Methods

Health Facility	Type of training	Number of providers
Majengo HC	Short-term methods	8
	Long-term methods	2
Pasua HC	Short-term methods	9
	Long-term methods	1
Kirua Vunjo HC	Short-term methods	6
	Long-term methods	2
Himo OPD HC	Short-term methods	5
	Long-term methods	2
Nyasho HC	Short-term methods	8
	Long-term methods	3
Bweri HC	Short-term methods	5
	Long-term methods	4
Suguti DSP	Short-term methods	0
	Long-term methods	0
Murangi HC	Short-term methods	4
	Long-term methods	4

Source: MoHSW training track 2015. The data regard the period from January 2010 to August 2015

Table 7.2: Number of providers trained on family planning and training organiser

Council	Training provided	Years										
		2010	Organiser	2011	Organiser	2012	Organiser	2013	Organiser	2014	Organiser	Total
Moshi MC	Short-term methods	11	MoHSW	22	MoHSW	8	CEDHA	1	MoHSW	0	-	42
	Long-term methods	2	EngenderHealth	0	-	0	-	7	MoHSW	1	EngenderHealth	10
Moshi DC	Short-term methods	7	Engender/MoHSW	27	CEDHA	12	EngenderHealth	17	EngenderHealth	0	-	63
	Long-term methods	5	EngenderHealth	0	-	11	EngenderHealth	14	EngenderHealth	5	EngenderHealth	35
Musoma MC	Short-term methods	0	-	0	-	5	EngenderHealth	14	MoHSW	6	CEDHA	25
	Long-term methods	0	-	3	MoHSW	17	EngenderHealth	0	-	0	-	20
Musoma DC	Short-term methods	22	MoHSW	4	MoHSW	4	MoHSW	12	EngenderHealth	0	-	42
	Long-term methods	6	MoHSW	4	MoHSW	0	-	0	-	0	-	10

Source: MoHSW training track 2015

The data were retrieved from the MoHSW training track system in August 2015. The data show the number of staff trained on family planning since inception of the NFPCIP January 2010 to August 2015. There were no data in the system that show the number of provider(s) trained in 2015

A majority of the providers in Mara region wished to have more staff that had been trained to provide family planning services; not only for the short acting methods but also for the long acting methods. They explained that they were not able to provide the long acting methods since they never attended any training on the provision of those methods. Even when providing other services, they just used experience acquired at the facility, without being trained on those methods.

> *'For me I wish that most of the providers would be trained on how to provide a family planning programme. When the person assigned to work in a family planning unit is not available. Another health worker can then provide family planning without a problem. For instance, if clients come and need an IUD I am not qualified to insert it. I am here but I do not have the skills and knowledge required for inserting the IUD.'* (P31: Health Provider)

7.3.3 Identification of training participants

The regional manager and the LGA managers said that EngendeHealth and CEDHA provided the training for free, without cost to LGAs. The organisation typically presented itself by sending a letter to a particular region and LGA, informing those government institutions that the organisation intended to conduct training on specified dates. The LGA was requested to identify a conference hall that would be convenient for all participants. Also, they were asked to select the providers who were to attend the training. The NGO then planned the training schedules while the regional officials and the LGA offices were just informed.

> *'This information includes the date when the training will be conducted together with a description of the training (either on short acting methods or long acting methods). The trainers are mainly coming from the LGAs. The DRCHco selects the providers who will attend the training. Sometimes the council involves the heads of the facilities to select the providers that will attend the training.'* (P36: RCHco)

After receiving the invitation to attend training from the organiser, the LGA would search for suitable providers to attend the training in case. For this purpose, the LGA managers assessed the number of clients' served at all facilities in the their LGA's and the training that the staff members already had attended. On this basis they selected the staff who would benefit from the training. Sometimes the training organiser had specific criteria for the staff who were to attend the training. Thus priority might be given to health workers that were providing family planning services but had not attended any training in that area yet. Sometimes a DRCHco would just send a message

requesting facilities to send staff members to attend the training. The head of facility (*facility in-charge*) together with the matron would then select someone to attend the training.

One of the facilities of Musoma DC had created its own way of regulating the training by keeping a record of all staff members attending any training, including all particulars of the training attended. When an opportunity to attend training arrived, a staff member who had not yet attended that training would go, even if the letter from the LGA specified another staff member.

> *'In our facility the doctor initiated a book in which records are kept for all who have attended training and the type of training attended. When there is a training offered, we look in the book and identify who will attend that training even if the district sends the name for someone to attend the training. The doctor will look in the book and if he sees that the staff member named by the district has recently attended any training, he selects another staff member instead. He says that you cannot repeat a training while others have not attended. He says: what happens if the one person selected every time dies, transferred or gets any problem! Who will be working in that section?'* (P30: Health Provider)

One provider from Moshi MC expressed doubt about the criteria used by the LGAs to select staff members for training. According to her, workers from other facilities were selected, even though they did not provide long acting methods while the provider who provides those services in her facility was not selected.

> *'Selection of somebody to attend training is problematic. For instance, a day before yesterday there was a training on how to insert Jadele (New Implant brand) and they did not select any staff from this facility to attend that training. Myself I have not attended any training on how to insert Jadele. I am just doing it based on the experience acquired at the facility. Ideally they are required to inform the facility-in-charge that a staff member is needed to attend the training. The in-charge will select the appropriate candidate.'* (P32: Health Provider)

The health secretary from one of the LGAs said that sometimes the LGA health department conducted a training in a three day session and termed it '*supportive supervision*'. They were organizing a training using LGA funds, but called it supervision, because supervision could be paid from the LGA funds and training could not. For this 'supportive supervision', the providers were gathered in one place for two or three days. However, according to the ministry guidelines, training on short acting and long acting methods cannot be conducted in less than either one or two weeks. Therefore, such a 'supportive supervision' is not a training in the sense of the guidelines.

7.3.4 Training attended

There was huge difference between the Kilimanjaro region and the Mara region in the amount of training received by providers. In Kilimanjaro, all facilities that were part of this research had at least one provider who was stationed permanently in the family planning unit and who had been trained in both short acting methods and long acting methods. In addition, two providers who were providing family planning services in Kilimanjaro (one from Moshi MC and another from Moshi DC) were themselves trainers. In Mara region many providers stationed at the family planning units had attended only training on short acting methods while others had never attended any family planning training.

One provider of a facility in Musoma DC, who only attended one training, in 1984, on the provision of short acting methods, was providing all methods. At another facility in the same district the family planning services were provided by a medical attendant who had never attended even the formal nursing and family planning provision training. She just used her experience and provided only short acting methods. In her own words:

> *'I never got any training, but I learned what I know in the facility, mostly about injections and pills. One of the basic principles is when the clients come in the facility you listen to their history. As you know, the MCH card number five contains a lot of observations including x-rays check-up. So when they come we try injection and when they return after three months we observe them if there are any problems.'* (P25: Health Provider)

7.3.5 Number of available staff trained on family planning

Only one of the DRCHco and council Health Secretaries was able to tell the exact number of staff members in his jurisdiction who attended a training on family planning provision. This exception was the DRCHco of Musoma DC. He could recall that four of the staff active in the district were trained in both methods and thirteen were trained in short acting methods. Table 7.2 (the training track system), however, shows that the Musoma DC had ten staff trained on provision of both methods and forty-two staff trained in provision of short acting methods. The information provided by the DRCHco thus was contradicted by information retrieved from the training track system. The reason for this difference was not clear, but it might have something to do with the selection of the staff that could attend the training. As explained above the selection of staff members was done by either the DRCHco or the health facilities' in-charges. Generally, the finding shows that record keeping

by the different LGAs shows a big difference. The numbers of the training track system are far higher than the number in the LGA's.

This LGA (Musoma DC) had one health centre and twenty-six dispensaries. Thus, not all facilities where family planning services were provided had providers who had attended training. The one DRCHco who was well informed also made the following remark:

> *'Also the ministry has directed us that for those providers who got training before 2009 are not considered to have been trained, since there are a lot of changes and updates which have taken place. So they should not be qualified as already trained; instead they should be trained again.'* (P23: DRCHco)

One of the providers in Moshi DC had attended several training sessions and she was a trainer as well. She had taken the initiative to train her subordinates on both short and long acting methods. She felt that training her own people had an advantage since she already knew the weak points of her subordinates. In her own words:

> *'One thing I need to stress is counselling. They need to know well how to counsel a client and to probe the client until she explains herself thoroughly. You know, there are clients who have the wrong perception concerning family planning and it demands techniques to probe them. That is an area where I see a need to work hard to train them. I think they will be very good providers once they master the counselling.'* (P27: Health Provider)

The overall image that arises out of these data is that of a great difference in the level of training between the two regions. The LGAs at Kilimanjaro region (Moshi MC and Moshi DC) had far more trained providers than LGAs from Mara region, the region with the lowest CPR.

7.4 The drugs ordering process and its outcome

Formerly, in Tanzania the drugs suppliers were using a kit system. With this system, the Medical Store Department (MSD) was distributing a kit with a standard content of drugs to all health facilities regardless of their need but according to nationwide statistics about diseases distribution and client needs. Later on the MoHSW changed from this system to an integrated logistics system. This system calls for each health facility to order the drugs based on its requirements.

The providers in the respective health facilities ordered the drugs they needed directly from the MSD. The providers and the DRCHco claimed that they usually did not get all drugs as ordered. Sometimes they received less

than ordered and sometimes they did not receive anything at all. Thus in all health facilities the availability of family planning drugs was one of the big challenges.

The Regional Medical Officer (RMO) of Mara region once took the initiative to go to the MSD Zone headquarters together with the regional pharmacist. They wanted to discuss with MSD officials what the underlying problem was that caused the MSD to fail delivering the requested drugs on time and in the right quantities. This RMO took the initiative after consultation with NGOs. One of the conclusions from this consultation was that the shortage of the family planning drugs was the main contributing factor for the observed low CPR in Mara region.

Most of the providers involved in the present research knew the procedure for ordering drugs and were ordering themselves. The others ordered through the matron of the facility. The providers who ordered drugs themselves usually got what they had ordered, unlike those who ordered through the matron. One provider from Moshi MC said that she sometimes was hoarding when ordering: instead of ordering a three month supply as required she would order a quantity for four months or more. When a next order would not be (completely) fulfilled by the MSD she would still have her stock available.

> *'I always overestimate the drug order to cover four months or above instead of three months. So, while waiting for the new stock of drugs I still have the stock from the last order. Most of time other facilities that have the shortage of drugs came to borrow in our facility. If the drug order calculation is done properly you will not run out of stock. I always order drug three month before the time.'* (P29: Health Provider)

The LGAs dealt with the shortage of drugs in different ways. In Moshi municipal council, Moshi DC and Musoma DC the missing drugs were borrowed - first from one facility to another within the LGA and when the stocks in all of the LGA were depleted, from a nearby LGA. Borrowing was not a practice in the Musoma MC because the managers knew that the shortage existed throughout the Mara region. Neighbouring councils were facing the same problem, so the MSD was the only place to request for drugs. Moreover, there is an emergency procedure (form C) that the facilities in Musoma DC sometimes used when there was an urgent need for a specific drug that was missing.

Some of the DRCHco took advantage of being in the vicinity of the NGO and institution headquarters to request missing items. In the words of the DRCHco from one LGA in Kilimanjaro:

> *'I was in Arusha so I went to the EngenderHealth Office (you know it's headquarter is in Arusha) and they gave me some drugs (Jadele) and I distributed them amongst the facilities.'* (P22: DRCHco)

Another method the service providers used to get the items they lacked, was requesting them from the NGOs after they had exhausted their facility activity. The providers said that the NGOs had family planning items in abundance, so it was always worthwhile to ask them for help. Others providers counselled their clients to change the method they were using, so as to match the available methods, while others just told the clients that the drugs were not available at the moment. Some of the clients did indeed change the method they were using, while others waited until the method of their preference had arrived at the facility.

> *'We do not do anything but when we have an outreach with our partner we request them to give us the lacking drugs. You know because they are NGOs therefore they have a lot of drugs.'* (P28: Health Provider)

Another provider commented that:

> *'For instance we do not have Implanon. I do not do anything rather than telling the client that we do not have that method in our facility…they just say I will wait until you get the new stock.'* (P32: Health Provider)

In summary, differences between the LGAs were found concerning: the amount of training attended by the providers of family planning services and the availability of drugs. The comparative results are shown in table 7.4. The LGAs from Kilimanjaro are better off than the LGAs from Mara region.

Table 7.4: Training and drug ordering process

Indicators	Moshi MC	Moshi DC	Musoma MC	Musoma DC
Provider trained on short-acting methods	+ +	+ +	+ +	+ -
Provider trained on long-acting methods	+ +	+ +	- -	- -
Provider is the trainer	+ -	+ -	- -	- -
Council knows number of provider trained on FP	-	-	-	+
Provider conduct on job training	- -	+ -	- -	- -
Provider order the drugs	+ +	+ +	+ -	- -
Council takes initiative to borrow the missing drugs	+	+	-	+
Exposure[10] in 7 items across LGA	High	High	Lowest	Lowest

Note: The two symbols, + and -, indicate the presence or absence of fallacies and the level of awareness (high or low). Each sign represents one of the two facilities in the council, hence two signs for one council.

7.5 Supervision process

The supervision of the health facilities by LGA officials was based on guidelines prepared by the ministry. The supervisors observed all the procedures pertaining to family planning service provision: drugs ordering, recording the clients' information in the ledger and the way the clients were dealt with from their arrival at the facility until they left, assessing those practices against guidelines. A DRCHco formulated this during an interview as follows:

> *'We first look into the availability of drugs and inspect the ledgers to see how the providers register the expenditure of the drugs. Also we observe book no. 8 and see how the clients are registered. We observe if the information is correctly filled out, especially in the MCH 5 cards which is the client's information card.'* (P21: DRCHco)

The experiences of the health workers with such inspections concurred with the picture sketched by the DRCHco. According to the latter, the supervisors from the LGA, the region and the ministry observed the whole facility, evaluating all family planning activities done. When the CHMT inspected a facility, the members of the inspection team divided themselves according to their respective areas. Those who were responsible for RCH services just evaluat-

10. The exposure ranking was obtained by dividing the possible score that is 12 by 4 LGAs to get the interval. Then the ranking was grouped into four categories i.e highest, high, low and lowest.

ed the RCH unit. The nursing officers went into the ward and observed what was being done there, while the doctors went to the doctors' room. The LGAs conducted supervision each month, however, one provider from Moshi MC declared that she did not gain anything new from these supervisions. She expected to have a practical demonstration on new skills during supervision: instead the explanations were always theoretical.

All DRCHco's interviewed said that their LGAs practiced monthly inspections. All facilities were visited once a month. They characterised their supervision as mainly '*supportive supervision*': the supervisor coaches the persons being supervised. The DRCHco at Musoma DC fed the information generated during supervision back to the facilities that had challenges observed during supervision and discussed with them possible contributing factors and ways to address shortcomings.

> *'For us we have like two types of supervision. In the first type of supervision all CHMT members conduct supervision each month. We use one car and all members are divided in different groups and assigned to different tasks. The second type is the one in which I go alone. I call it as supportive supervision. I go myself to each facility. I may decide today I will be at certain facility and spend the whole day in that facility working together with the providers. At the end of a day we sit together and if there any challenges we discuss them together.'* (P23: DRCHco)

Some of the respondents remarked that the supervision of family planning might be postponed if there was no transport. The evaluations of other programmes (such as immunisation) were never postponed. At the municipal councils the managers occasionally used their private car if transport was lacking, since the facilities are close to their office and the facilities were also close to each other.

During an observation of a supervision process in Moshi MC it was noted that the supervisor merely observed the room and made notes. At last she asked the provider if she was encountering any problems. The provider replied, '*I do not have any problem apart from a shortage of Jadele*'.

In general, all LGAs were conducting monthly supervisions adopting the same procedure as the one used by central government (the region and the ministry).

7.6 Community outreach services

In several areas, community outreach services are a common practice. This practice involves the provision of health education in relation with the family planning programme with an aim of creating community awareness through advocacy and sensitisation. Moreover, it involves the provision of family

planning services to the clients who are living in areas that are hard to reach or do not have health facilities that provide those services.

NGOs such as EngenderHealth did from time to time provide additional services at the facility level. They would not go down to the communities themselves however - to provide family planning services, community sensitisation and education on family planning. '*Donors do not go beyond the facility. They just go to the facility only. When they go to the facility their services are the same as the services we provide everyday'* said one DRCHco. What NGOs did different was that they announce they would be in a certain facility, so the community might understand that there would be family planning services provided by NGO.

With the exception of Musoma DC and Murangi health facility from the same council, the LGAs and facilities did not conduct family planning outreach services. What they mainly did, terming it outreach services, was requesting those NGOs they were working together with, to provide long-acting methods after conducting training on IUCD insertion or requesting for a Minilap. One of the DRCHco said in an interview:

> *' In reality the outreach services are not done always: we just do it when we have funds. Family planning services is only provided at health facilities. For the client to travel on foot five or six kilometres to get an injection or to travel with a 'Bodaboda' motorcycle taxi and pay Tsh. 2000 or Tsh. 3000 is not possible. But when we bring the services closer to where they live they attend. So if we were conducting an outreach services every three months we could get a lot of clients. Instead we just wait for those who come at facility, and those who come to the facility we do not look for them instead they are coming voluntarily that why we only have 10% acceptance rates.'* (P23: DRCHco)

The DRCHco from Moshi MC said that they did not see the need to conduct outreach services since the health facilities are distributed evenly across the area.

> *'Community outreach…. We do… do… the community outreach we do it at health facilities, we go to a facility let's say Kiboriloni and conduct a minilap or we may say we want to do at Pasua as we will do this week with EngenderHealth. We do not go to a community per se and conduct sensitisation. We do not, may be because we have many health facilities and they are so close to each other.'* (P22: DRCHco)

The health secretary of the same LGA provided a similar statement:

> *'The geographic location is very small. We have sixteen wards and among those wards only four do not have a government facility. Yet those*

four have a private facility that provides the same services which we provide in public facilities… you cannot walk more than two kilometres without coming across a facility.' **(**P34: Health Secretary)

Most of the LGAs had a budget for outreach services in programmes such as vaccination, but not for family planning. The following explanation, given by DRCHco, is plausible: any request for funding family planning outreach meets strong resistance in the LGA's council meeting. The refusal is motivated with: *'family planning has a lot of donors while we do not have budget for that',* despite the fact that the NGOs do not provide any outreach services.

In conclusion, only one health facility from the Musoma DC did conduct the community outreach services. Other LGAs did not conduct the community outreach services either because they had health facilities distributed evenly across LGA or they did not have the budget to facilitate this activity.

7.7 Awareness and acceptance of family planning services by the community

Due to changes in economic and social factors, in many communities public opinion about family planning has been changing. Many people started thinking about using family planning services to plan the number and also the timing of children. In Mara region, the awareness and the acceptance rate were still low, especially amongst men, while in Kilimanjaro the acceptance rate was very high. Therefore, in the Kilimanjaro region the demand for contraceptives was large, larger than the availability. Incidentally, it seems that religion had little bearing on the acceptance rate. The Roman Catholic faith for instance had a strict ban on the use of contraceptives. Nevertheless, many Catholic clients made unrestricted use of family planning tools, according to council managers and providers.

The rate of awareness had consequences for the way clients handled family planning. The evidence collected through interviews shows that in Moshi MC and Moshi DC the awareness was high and that most men supported family planning. This was different in Musoma MC and Musoma DC where the acceptance amongst men was low. The male aversion towards anti-conception caused many women to use the services secretly.

'For the community still has low awareness especially the men. Females know and they are using but males' awareness is very low. Women come and say they want to use the contraceptive but their husbands do not want. When you go to their husbands they tell you these drugs cause cancer. You understand that these men still need health education. In summary for women the awareness and knowledge is high but for men is still low.' (P23: DRCHco)

Another provider commented that:

> *'For instance the client may ask you to serve her quickly, so that her husband cannot find her using the services. This may cause her to fail to use the services properly since she is afraid of her husband. She may go beyond the prescribed date for the next dose. During the female sterilisation there are some women who come without the consent of their husband… what should she do? She already has 9 children; others have 10 to 12 children.'* **(**P26: Health Provider)

In addition, the male aversion caused clients to prefer injection, because this method could be utilised secretly, without the knowledge of the husband. In other places it is customary that the man makes the decision in the family. They even decide about the number of children the family should have: under these circumstances women did not have the choice to use a birth control method.

> *'You know in this region, male decides the number of children to have and when to have another child. Women do not have say on the number of children they want. May be for young women, during those days we did not have any say on the number of children we wanted but the male was the one who decided.'* **(**P24: DRCHOco)

This aversion had a huge impact on women's decision concerning the use of contraceptives. Women had even been bitten by their husband simply because they had used a contraceptive without permission from their husband. One example was the story told by a provider from Nyasho Health facility from Musoma MC.

> *'For instance last week a woman came in here. Her husband had bitten her, and then divorced her because she used an implant while her husband was not aware. She was coming from Serengeti. She was bitten and had a lot of wounds.'* **(**P31: Health Provider)

Another attitude that had an impact on the acceptance of family planning regarded the size of the family. Some people in rural areas in the Mara region still believed that children formed their wealth. They strongly preferred a large family, more than ten children. So when someone advises them on the issue of planning their family they consider this as interference in their customary ways.

Generally, men from the Mara region had low levels of knowledge and awareness towards family planning services and that caused them to have a negative perception towards the programme. This led to most of their spouses using contraceptives secretly.

7.8 Other organisations that provide family planning services

Other institutions that supported and supplemented the efforts of LGAs in the provision of family planning services were the *Zonal Health Resource Centres, NGOs* and the so-called *Community Based Distributor* (CBD).

In the researched LGA-cases, two NGO's and one institution were reported to be active: PSI, EngenderHealth and CEDHA. PSI was specialised in the provision of short-term methods; EngenderHealth was dealing with supplying long-acting methods and permanent methods. It also conducted training on family planning. CEDHA was mainly dealing with the training of providers for applying short acting methods. According to the DRCHco and the health providers EngenderHealth was the main player; it had a large contribution compared to other NGOs and institutions. It supported different aspects including supervision.

> *'EngenderHealth came to provide services. When they came they had everything so they just requested the place (facility) for them to provide the services. This means they handled everything from transports to the allowances for health providers: and what they needed from us was to make arrangements and allocate the staff that will be involved in that activity. They help us a lot even the coverage is becoming high because of them.'* (P22: DRCHco)

This shows that the LGAs did not have control over these NGOs and institutions. They had to wait until they got a call from an organisation announcing that they were to conduct this training or provide that service. The LGA then could prepare a list of providers/staff that would participate in the training or arrange the facility where the service would be delivered. However, one DRCHco from Mara region took an initiative and prepared a list of providers who were working in the family planning units with the training they had attended. He sent this list to the NGOs and requested them to conduct training for family planning for the health workers in his LGA.

Because the long-acting and permanent methods were generally provided by NGOs, some of the LGAs were concentrating on the provision of the short acting methods, especially in the Mara region. In the words of the council health secretary from Mara: '*the council is mainly dealing with short acting methods and NGOs will deal with long acting methods'*.

During fieldwork at Moshi municipal council, the researcher conducting the present study had an opportunity to observe, in one of the facilities, the

conversation between a provider, workers from PSI and workers from EngenderHealth. The PSI was observing how family planning services were provided and EngenderHealth was arranging for a Minilap procedure that was to be conducted at the same facility.

While observing the family planning provision process, one follow-up client came in to receive a contraceptive by injection. This client had used injection for more than five years. After she received the contraceptive and left the room, the worker from PSI asked the provider: *'did you ever counsel clients who use a short acting contraceptive for a long time to change'?* The worker from PSI continued saying that using a short acting contraceptive for a long time is not economical. In addition, research had revealed that the use of a short acting contraceptive had more side effects than long acting methods: side effects such as a failure to conceive and even cancer. The provider responded that she sometimes attempted to educate clients but they did not want to change. She could not force them to switch methods.

After office hours the researcher gave a worker of EngenderHealth (who was making arrangements for a Minilap) a ride to the LGA office. During the ride he asked her about the procedure she should follow to arrange the Minilap. She told the researcher that she sent a request letter to the LGA office explaining the intention of conducting the Minilap. After gaining permission from the LGA she went to the facility to make arrangements. She arranged for staff members that would be involved (nurses, a doctor) and equipment that would be used. The nurse she engaged was the family planning provider at the facility and the doctor was coming from the neighbouring LGA. The equipment was coming from two facilities in the same LGA. In addition, she said that currently she was organizing Minilap procedures that were requested by the provider of a facility and she already had a list of fifteen clients who needed a Minilap. The provider invited the clients to come on stated dates for the service.

The scenario above shows that a provider might influence the services to be offered in her facility. Moreover, the provider who requested the Minilap was one of the trainers engaged by these NGOs to give training. Knowing the workers from these NGOs and being close to their offices created the opportunity for NGOs to provide the long-acting and permanent methods in their facility.

Only Moshi DC had a Community Based Distributor (CBD). A CBD is a member of community that provides indoor services in the more remote wards in the geographic area of the LGA. They are supported by the LGA health system and received two weeks of training on family planning. They mainly distribute the short-term contraceptives: pills and condom. The CBD was active in sixteen out of thirty two wards. It was in the planning of the LGA to extend its activities to all wards. However, at the time of the research the LGA did not have the budget to conduct training to new CBDs. The train-

ing for the available CBDs was done in 2010 with support from the NGO known as Pathfinder.

One can hardly overemphasise the importance of NGO's and the like for the success of local family planning programmes. Especially EngenderHealth has become an NGO that plays a large role in the provision of family planning services in all LGAs.

7.9 Challenges perceived by managers and providers

Availability of contraceptives was the main challenge that was perceived in all LGA-cases. As mentioned before, one major cause of shortages was that orders for medical supplies were not adequately filled. Because of shortages the facilities often lacked the method mix (availability of a wide range of family planning methods), as recommended in the guidelines. The problem was most pronounced in the LGAs in Mara region. The facilities there reported that they always ran out of stock with the long-acting contraceptives. Usually they had sufficient supplies of injections.

> *'Currently, we have a lot of depo and a few implants but we do not have IUD's. But when you are providing health education you explain to the clients all FP methods. After, counselling the client tells you that, 'as you have told me the IUD have few complications because is inserted in uterus and does not have any hormone. So I will use the IUD'. When the client decides to use the IUD and it is out of stock, to inform her it is not available is very difficult. When you tell her that the IUD is not available she will leave without using any methods: because you already told her the complication (disadvantages) of other methods. She may tell you I will come another time: for you to lose the clients is so painful.'* (P23: DRCH-co)

The major problem that facilities in the Mara region encountered was a shortage of staff. Many facilities there just did not employ sufficient staff to have providers of family planning services stationed permanently in the family planning units. The staff providing family planning worked in other departments as well. There was one exception: in a facility from Musoma DC the provider worked permanently in the family planning unit. Yet the reason why this provider was stationed permanently in the family planning unit had not much to do with a quest for quality; she had recovered from a stroke and the family planning unit apparently was thought to be the least demanding part of the facility. In the Kilimanjaro region all LGA-cases had providers who were permanently stationed in the family planning unit.

One of the obstacles that facilities in Moshi DC had to cope with was religious inspired opposition, especially from the Roman Catholic Church. In

places where a Roman Catholic organisation owned the health facilities no family planning services were provided. Usually, the religious leader resisted the provision of family planning services. Catholic clients were afraid to use the contraceptives openly, since they might be expelled from the church if they were caught. To protect themselves, some bought the methods from a private pharmacy.

Table 7.5 summarises the differences between LGAs concerning community outreach; clients' awareness and acceptance; other organisations that provide family planning and allocation of health provider permanently in family planning unit. The differences were observed in conducting community outreach, male awareness and acceptance of the programme and provider stationed permanently in family planning unit. The men in the Mara region had low awareness and acceptance that caused most of women to use injection, which was a method that can be easily used secretly.

Table 7.5: Councils differences in community awareness, acceptance; other providers who provide services, and perceived working challenges

Indicators	**Moshi MC**	**Moshi DC**	**Musoma MC**	**Musoma DC**
Community outreach	Not done	Not done	Not done	Done
Awareness and Acceptance				
Male	High	High	Moderate	Low
Female	High	High	High	High
Other organisations provide FP services				
CEDHA	Yes	Yes	Yes	Yes
EngenderHealth	Yes	Yes	Yes	Yes
CBD	No	Yes	No	No
Provider working permanent in FP unit	+ +	+ -	- -	+ -

Note: The two symbols, + and -, indicate the presence or absence of providers. Each sign represents one of the two facilities in the council, hence two signs for one council.

7.10 Concluding remarks

As was pointed out in the introduction to this chapter, three properties, adherence, exposure and monitoring and control, were used to compare programme implementation across four LGAs. The adherence was examined by analysing the LGA planning process. The exposure was operationalised as; (1) training process (2) number of available workers trained on family planning and stationed in unit (3) family planning drugs ordering process and (4) number of outreach (community advocacy) done. Monitoring and control was assessed by analysing the supervision process. The differences in community

awareness, acceptance, other institutions that provide family planning and perceived working challenges were examined as well.

It was noted that Moshi DC and Musoma DC did realise that there were low family planning prevalence rates in their jurisdictions. Both LGAs decided to include family planning in their CCHP and developed the strategies to raise CPR. Musoma MC too realised that the CPR was low though did not set any strategy to raise it. The Moshi MC did not write anything on family planning in their CCHP.

EngenderHealth, CEDHA and the ministry facilitated most of training conducted in the LGAs studied. The trainings were organised by these organisations and DRCHco and facility in-charges identified the eligible providers who would attend. The data showed that there were substantial differences between the Moshi municipal council, Moshi DC, Musoma MC and Musoma DC concerning the knowledge and skills of providers working in family planning unit across LGAs. Health providers working in family planning units in the Moshi MC and Moshi DC were trained in both short acting methods and long acting methods while those from Musoma MC were trained in short acting methods only. The situation was worse in Musoma DC where in some of facilities family planning services were provided by medical attendants who did not even attend the nursing training.

In most areas the providers themselves ordered the medical supplies for family planning. The provider did the drugs ordering themselves. Often they did not receive all the items from MSD as they order. In Moshi Municipal council and Moshi DC all providers ordered the drugs themselves but in Musoma MC and Musoma DC some of the providers requested the drugs from the matron. The matron then ordered the supplies from MSD. Most of facilities would borrow from another facility within the LGA when they encountered a shortage of drugs. When the supplies in a LGA were depleted, attempts were made to borrow from other LGAs or to solicit supplies from NGOs.

With an exception of one facility from Musoma DC, the LGAs did not conduct family planning outreach services. What was usually done was requesting the NGOs to provide long acting methods, IUCD and Implants; and permanent methods (minilap) in their facilities.

All LGAs conducted supervision every month. The conducted supervision was mainly mentoring and supportive supervision. In some LGAs the supervisions were postponed when the funds to facilitate these activities were lacking.

Chapter 8

Programme delivery at health facilities

8.1 Introduction

The health facility is the place where the family planning programme services are delivered. Here the programme is transformed from papers and directives into action. To ensure that *quality* services are delivered, the programme is supposed to be delivered in accordance (*adhere*) with the different guidelines, and directives received from higher level. However, there might be some *adaptation* done with the providers to accommodate the context where programme is implemented.

This chapter describes how the health services providers conveyed programme commodities and services to clients. It starts with the analysis of the quantitative data collected from an observation of the services delivery at seven health centres and one dispensary: two health centres from Moshi municipal council, Moshi DC and Musoma MC and one health centre and one dispensary from Musoma DC. Then follows an analysis of qualitative data collected from the observations and interviews conducted with health providers and clients in health facilities visited. The main thrust is to describe whether there is difference in facilities programme implementation practices.

According to National Family Planning Procedure Manual, family planning services are provided at different levels. Starting with the lowest level there is first the community, then the dispensary, the health centre and at the top the hospital level. The services at the community level include the deliverance of IEC[1] materials and barrier methods (mainly condoms). The dispensary offers health education, the screening of clients for family planning and Sexual Transmitted Infections (STIs), barrier methods, injectable methods, pills and IUD. The health centre makes all services available found at the dispensary level, with the addition of implant insertion and removal. Sometimes the facility organises preparatory activities for minilap surgery. Lastly, at hospital level all methods found at the lower levels are provided, with the addition of surgical procedure (minilap).

1. Information, Education and Communication (IEC), are materials used in the process of informing, educating and communicating issues to clients for behaviour change towards family planning.

Ideally, a dispensary is run by a clinical assistant who has attended two years of training in anatomy, physiology, hygiene, diagnostic methods, and treatment of common illnesses. He/she will be assisted by an enrolled nurse with two years of training in nursing care of minor illnesses. Dispensaries provide maternal and child health care, treat simple medical problems during pregnancy such as anaemia, assist normal deliveries and offer basic outpatient curative services. The second formal level of health services provision is the health centre. The health centre is headed by a Clinical officer with three years of basic clinical training. Enrolled nurses support her/him. However, some of the health centres in municipal councils are headed by Assistant Medical Officers (AMOs), a clinical officer with additional 2 years of training and a Medical Doctor. Although the health centre is intended to provide curative and preventive services, it also has ten to twenty hospital beds, provides all reproductive and child health services and performs minor surgeries. In this context the chapter will discuss the programme *exposure*, *quality* of family planning service delivery, provider *adherenc*e with procedure and standards and *adaptation* at health centres. The reasons for selecting the health centre were discussed in detail in chapter 4.

Each health facility is supposed to have at least one designated health worker who provides family planning services and other RCH services. It is worth to note that the family planning services provision in Tanzania is a walk-in process. The client walks into the health facility and explains the reasons for her visit. The provider then gives the client the advice and services sought for.

The following sections capture and analyse programme *exposure, quality* of services delivered, *adherence* with guidelines and procedures and the *adaptation* strategies adopted by family planning providers. Two parameters of programme *exposure* were examined: provider training attended and the amount of programme documents received by facilities. The *quality of the services* delivered was operationalised into two categories: *client care* and *counselling and education*.

Moreover, the chapter assesses the availability of family planning methods, working environments, working tools; and the relationship between provider, supervisor and co-worker. These are environmental factors that may affect the *quality* of services delivery in one way or another. Also it might cause some sort of *adaptation* by the providers as a coping strategy to provide family planning services at their health facilities. The coping strategy deployed by providers might affect the programme negatively or positively. The last section will describe and analyse such strategies.

8.2 The quality of family planning services

8.2.1 General

The *quality* of family planning services offered was operationalised in a number of properties including: provider's technical competences, information given to clients, general clients' care and education and counselling. The providers' competences are one of the indicators for the *quality of services* delivered to the clients and the 'quantity of the medical supplies available' is another one (Lantis, Green and Joyce 2002; Mosadeghrad 2014). The *dosage* of training attended by the providers mainly influences these competences. The providers who had attended several trainings were more skilful and more likely to provide quality services than the providers who had attended less training or never attended any training. The level of skill of the providers affects the family planning provision process positively or negatively, which in turn predicts the *quality of service* delivered (Agwanda, Khasakhala and Kimani 2009).

8.2.2 Level of training of providers

All providers working in the facilities included in the research sample were women from the community in which they were working. Being part of the community enabled them to be aware of the obstacles facing the clients in using family planning services. There was a notable difference in training attended by providers among the four LGAs cases (see chapter 6 and 7). All providers in Kilimanjaro had attended training on the provision of short acting and long acting methods while one provider had been a trainer in each of the two LGA's. At Mara, the highest form of training providers had attended was in short-acting methods. A number of providers, especially at Musoma DC, did not attend any family planning training. The differences in level of training were noticeable in the way providers dealt with their clients. The one provider who had herself been a trainer for instance, spent an average of 45 minutes with each client, explaining the available methods in the facility; the advantages and disadvantages, who is eligible to use it and why. The providers who had attended training on short acting methods only merely asked the client what methods she (client) wanted and gave what was asked for without discussing methods available at the facility; nor their advantages and disadvantages.

In the following sections we examine the differences in quality of services provided by these providers.

8.2.3 Quality of family planning services offered

The quality of services offered was operationalised in a number of indicators grouped into two main categories: 'client care' and 'counselling and education'. Client care was broken down in three variables: interpersonal relations, routine procedure and general client care. 'Counselling and education' was split up in four indicators:

1. Did the provider ask the client the reason for the present visit?
2. Did the provider ask for demographic information?
3. Was there an enquiry about the client's reproductive history?
4. Did the provider discuss all options available, so as to enable The client to make an informed choice?

The values of these variables have been computed from a list of indicators observed during services provision as discussed in chapter 4 and shown in table 4.4. All indicators are dichotomous variables, so YES mean quality, NO means lack of quality.

A t-test and ANOVA were applied for the analysis of the sub-variables of 'client care' and 'counselling and education'. The 'client care' and 'counselling and education' categories have been treated as the dependent variables. The regions together with LGAs have been treated as independent variables. The findings are presented in table 8.1 and 8.2. The highest mean score that the region/council could score was 1, the lowest was 0 and 0.5 was an average score. Therefore, the region/LGA that had mean score above 0.5 was assumed to have high quality services delivered, 0.5 an average quality services delivered and below 0.5 low quality services delivered.

As illustrated in table 8.1, the t-test values showed significant variation in mean score between Kilimanjaro and Mara region ($p<0.0001$). The Kilimanjaro region had a higher *quality of services* score than the Mara region. Although both regions had below average mean scores in *quality of the services*, 'counselling and education' had average scores for one region. The Kilimanjaro region had an average mean score, whereas the Mara region still had a low mean score.

Table 8.1: Differences between regions in quality of services provisions

Variables	Region/district	N	Mean (SD)	t	P-value
Compound quality	Kilimanjaro	66	0.49(0.28)	7.68	0.000
	Mara	49	0.19(0.13)		
Client care	Kilimanjaro	66	0.46(0.29)	7.48	0.000
	Mara	49	0.15(0.15)		
Interpersonal relation-ship	Kilimanjaro	66	0.49(0.35)	4.47	0.000
	Mara	49	0.26(0.21)		
Routine procedure	Kilimanjaro	66	0.45(0.30)	7.03	0.000
	Mara	49	0.12(0.21)		
General client care	Kilimanjaro	66	0.42(0.42)	7.61	0.000
	Mara	49	0.01(0.07)		
Counselling and Education	Kilimanjaro	66	0.50(0.29)	7.11	0.000
	Mara	49	0.21(0.14)		
Asking reason for present visit	Kilimanjaro	66	0.65(0.35)	8.01	0.000
	Mara	49	0.17(0.27)		
Asking for demo-graphic information	Kilimanjaro	66	0.72(0.29)	3.86	0.000
	Mara	49	0.48(0.36)		
Asking for client reproductive history	Kilimanjaro	66	0.41(0.31)	6.62	0.000
	Mara	49	0.11(0.17)		
Informed choice	Kilimanjaro	66	0.38(0.38)	5.40	0.000
	Mara	49	0.12(0.11)		

Table 8.2 shows the significant means differences between four LGAs across different indicators of quality ($P<0.0001$). The higher the value of F, the higher the mean differences. Moshi district and Musoma DCs had higher quality scores than Moshi MC and Musoma MC. The possible explanation for the observed differences was the number of clients served in relation to the number of providers. The municipal facilities had more clients who were in need of family planning services than the district councils while the number of staff in the family planning unit was everywhere the same. This caused the staff in the municipal councils to skip some of the procedure, so that they could manage to attend to all clients that needed the services. Some clients remarked that an increase in the number of providers would reduce the waiting time and increase the *quality of services*. The providers themselves said that the number of providers who were trained in family planning should be increased, so that they could help each other out during busy hours.

It is striking that only Moshi DC is scoring satisfactorily. The three other LGAs failed to meet the .50 criterion. The two LGAs in the Mara region had a low quality of services delivery in all variables compared to the LGAs from Kilimanjaro. As discussed in chapter 6 and 7 the providers who were provid-

ing the family planning services in Kilimanjaro LGAs had already attended the training in provision of all methods but also two of them were trainers as well. Thus these providers were best prepared for providing family planning services.

Table 8.2: Differences between councils in quality of services provisions

Variables	Region/district	N	Mean (SD)	F	P-value
Compound quality	Moshi MC	44	0.40(0.24)	27.76	0.000
	Moshi DC	22	0.67(0.26)		
	Musoma MC	38	0.18(0.13)		
	Musoma DC	11	0.23(0.15)		
Client care	Moshi MC	44	0.34(0.23)	37.32	0.000
	Moshi DC	22	0.70(0.25)		
	Musoma MC	38	0.15(0.14)		
	Musoma DC	11	0.14(0.17)		
Interpersonal relationship	Moshi MC	44	0.41(0.29)	9.31	0.000
	Moshi DC	22	0.65(0.42)		
	Musoma MC	38	0.26(0.20)		
	Musoma DC	11	0.23(0.26)		
Routine procedure	Moshi MC	44	0.34(0.24)	29.14	0.000
	Moshi DC	22	0.68(0.28)		
	Musoma MC	38	0.12(0.20)		
	Musoma DC	11	0.13(0.22)		
General client care	Moshi MC	44	0.19(0.25)	76.42	0.000
	Moshi DC	22	0.86(0.35)		
	Musoma MC	38	0.01(0.08)		
	Musoma DC	11	0(0)		
Counselling and education	Moshi MC	44	0.42(0.27)	20.91	0.000
	Moshi DC	22	0.65(0.27)		
	Musoma MC	38	0.19(0.14)		
	Musoma DC	11	0.27(0.14)		
Asking for reason for present visit	Moshi MC	44	0.52(0.34)	35.27	0.000
	Moshi DC	22	0.91(0.18)		
	Musoma MC	38	0.17(0.29)		
	Musoma DC	11	0.15(0.23)		
Asking for demo-graphic information	Moshi MC	44	0.68(0.30)	7.37	0.000
	Moshi DC	22	0.81(0.26)		
	Musoma MC	38	0.44(0.38)		
	Musoma DC	11	0.64(0.22)		
Asking for client reproductive history	Moshi MC	44	0.35(0.32)	15.15	0.000
	Moshi DC	22	0.51(0.26)		
	Musoma MC	38	0.10(0.17)		
	Musoma DC	11	0.14(0.15)		
Informed choice	Moshi MC	44	0.29(0.34)	13.71	0.000
	Moshi DC	22	0.58(0.39)		
	Musoma MC	38	0.11(0.07)		
	Musoma DC	11	0.15(0.20)		

Table 8.3 shows that only two health facilities, Himo OPD from Moshi DC and Majengo health centre from Moshi MC, had a *quality* of services delivery mean score above averages (0.5).

Table 8.3: Differences between facilities in quality of services provisions

LGAs	Facilities	N	Mean (SD)	F	P-value
Moshi MC	Majengo HC	17	0.64(0.17)	32.82	0.000
	Pasua HC	27	0.33(0.18)		
Moshi DC	Kiruwa Vunjo HC	10	0.44(0.14)		
	Himo HC	12	0.87(0.08)		
Musoma MC	Nyasho HC	24	0.27(0.15)		
	Bweri HC	14	0.15(0.12)		
Musoma DC	Murangi HC	4	0.36(0.21)		
	Suguti DS	7	0.21(0.07)		

8.2.4 Explaining differences in quality between regions

A logistic regression analysis was done to determine the variable(s) associated with the quality of services delivery that explain the probability of having high CPR from 115 cases observed in eight health facilities. This involves the transformation of dependent variables, low CPR (0) and high CPR (1) to logit, natural logs of odds. In this way the logistic regression estimates the odds of high CPR as compared to low CPR. The predictors were the variables contained in 'client care' and 'counselling and education'.

Table 8.4 shows that the one indicator of 'client care', (general client care) and two indicators of 'counselling and education' (provider asking reason for present visit and asking for reproductive history) are associated with high CPR: $p<0.05$ with model fit 60.6% (Nagelkerke R Square). The region whose providers did general client care had the highest likelihood of having a high CPR. Likewise, the region of the providers who asked the clients about the reasons for the present visits and about reproductive history had a likelihood of 20 and 18 respectively of having a high CPR as compared to the region whose providers did not do so.

Table 8.4: Factor(s) that explains the regional differences in Contraceptive Prevalence Rates

	B	S.E.	Wald	df	Sig.	Exp(B)
Interpersonal relations	-1.562	1.363	1.314	1	0.252	0.21
Routine procedure	0.984	1.704	0.334	1	0.564	2.675
General client care	6.22	2.489	6.247	1	0.012	502.926
Reason for present visit	3.011	1.104	7.434	1	0.006	20.309
Asking for Demographic information	-1.302	1.028	1.604	1	0.205	0.272
Asking for client reproductive history	2.882	1.632	3.117	1	0.077	17.848
Informed choice	0.129	1.583	0.007	1	0.935	1.138
Constant	-0.974	0.512	3.612	1	0.057	0.378
Model fit (Nagelkerke R Square) 0.606						

The data from this table (8.4) can be compared with the data in table 8.1, the table that shows that the Kilimanjaro region (the region with a high CPR) had a higher mean score for the same variables. The results suggest that improving these three aspects would have a significance influence in increasing the number of clients who use contraceptives, and hence increase the CPR.

8.3 Family planning coverage (programme reach)

Table 8.5 shows that in 2014 Mara region had a higher number of new clients than the Kilimanjaro region. This was attributed to the fact that Musoma DC (from Mara region) was the LGA with the highest number of new clients for the year 2014 in most of the available methods: table 8.6. This seems to confirm the comments given by a ministry official (P40) (presented in detail in chapter 6 and 7) that *'the greater efforts are directed to the lake zone'*. Yet this was merely a statement, since there was no evidence showing an increase of the provider training (*exposure*) and an increase of *quality of services* offered. If indeed the greater efforts were directed toward Lake Zone, this should be reflected in the funding, *the training*, the *adherence, the quality of services* offered and the *programme reach*. But what is reflected in the tables is only the *programme reach.* The '*greater effort'* mentioned by a ministry official (P40) might refer to the outreach services that were conducted at Musoma DC. As elaborated by DRCHco:

> *In 2010 the LGA with lowest CPR was ours. Different NGOs and regional office made a lot of effort where we managed to conduct an outreach services in all 61 villages of this council. (P23: DRCHco)*

It appears from table 8.6 that these outreaches were concentrating on the provision of long-acting methods.

In general, the Musoma DC had the highest increase in the new clients in 2014, followed by Moshi MC and Musoma MC while the last one was Moshi DC. For those clients who had already used family planning services (returning clients), the CPR differed with the new clients registered in 2014 across the LGAs. The LGA with the highest CPR for returning clients was Moshi MC followed by Moshi DC, Musoma MC and lastly was Musoma DC. This corroborates with the TDHS 2010 data.

Overall total of new and returning clients shows that, the Moshi MC had the highest number of clients received contraceptives followed by Moshi DC, Musoma DC and last was Musoma MC. This reflects that the Moshi MC have highest level of *programme reach* while Musoma MC had the lowest level.

8.4 Family planning services utilisation

Table 8.7 illustrates the observed regional and LGAs differences in the methods mostly used by clients. Both regions had relative high uses of injection. Kilimanjaro had also a high use of long acting methods. Likewise, all LGAs had higher use of injection than other methods except Moshi DC that had high percentages in the use of the long acting method (implant). This result indicates that the higher use of long acting methods reflected in the District Health Information System (DHIS) for Musoma DC in 2014 was primarily the outcome of NGO activities rather than the result of implementation activities by the health facilities.

Table 8.5: Family planning coverage in 2014 by methods

		New Clients												Returning clients					
Region	Population	IUD	CPR	Pills	CPR	Minilap	CPR	Injection	CPR	Implant	CPR	Total	CPR	Pills	Injection	Total	CPR	Total	CPR
Kilimanjaro	409159	8893	2.2	8235	2	5414	1.3	17768	4.3	19220	4.7	59530	14.5	23258	94583	117841	28.8	177371	43.4
Mara	410676	12704	3.1	4533	1.1	12787	3.1	28512	6.9	28836	7	87372	21.3	3938	39970	43908	10.7	131280	32

Source: District Health Information System (DHIS) 2014.

The population was the women of reproductive aged 15-49 years. Contraceptive Prevalence Rates (CPR) was calculated by taking the methods used divide by the total population times one hundred

Table 8.6: Family planning coverage in 2014 by methods

		New Client												Returning Client					
Councils	Population	IUD	CPR	Pills	CPR	Minilap	CPR	Injection	CPR	Implant	CPR	Total	CPR	Pills	Injection	Total	CPR	Total	CPR
Moshi DC	113,038	1908	1.7	1851	1.6	938	0.8	3541	3.1	4014	3.6	12252	10.8	5970	22482	28452	25.2	40704	36
Moshi MC	59,236	1757	3	1611	2.7	390	0.7	2800	4.7	2429	4.1	8987	15.2	3169	13739	16908	28.5	25895	43.7
Musoma DC	40,929	1306	3.2	271	0.7	1471	3.6	2890	7.1	3362	8.2	9300	22.7	185	5363	5548	13.6	14848	36.3
Musoma MC	37,617	449	1.2	405	1.1	331	0.9	2302	6.1	1052	2.8	4539	12.1	811	7257	8068	21.4	12607	33.5

Source: DHIS 2014. The population was the women of reproductive aged 15-49 years.

Table 8.7: Methods clients used most by the Region and LGAs

Region	Implant	IUD	Pills	Injec jec-tion	Condom	Counsel-ling only	No method received
Kilimanjaro	18	5	7	31	0	7	1
Mara	2	0	2	34	1	1	9
LGAs							
Moshi DC	10	1	3	5	0	6	0
Moshi MC	8	4	4	26	0	1	1
Musoma DC	1	0	0	9	1	0	0
Musoma MC	1	0	2	25	0	1	9

Also table 8.7 shows that at Moshi DC, 6 clients received counselling only, without being given any methods. In addition, there were 9 clients at Musoma MC that did not receive any method. This variation could be explained with the following information. One provider from Moshi DC was far more trained than other providers. The provider was doing her job better than other providers by taking extra time to counsel the clients to ensure informed choice. She managed to do this because she had few clients and took enough time to talk to the client to get a clear picture on different contraceptives available and which one the client could use. Generally, she was more precise and spent more time with clients than other colleagues from other facilities.

For instance, during the services provision process at one facility in Moshi district it was observed that one client wanted an implant, because she already received advice from her sister on what method she should use. Her sister had received an implant six days before in the same facility. The provider asked her if she ever used another method before. The client replied that she was using injection and that she was experiencing some problem (heavy menstrual bleeding three times a month). She continued saying that a provider from a dispensary in Kibosho, where she used to go for family planning services, had advised her to use an IUD. The provider told her that the advice from Kibosho was sound, because the method she was proposing (implant) had the same type of hormones as the injection she did not want to use anymore. After a long discussion the client said: *'my sister already told my husband that the implant is a good method and we agreed that I would use implant, therefore, I cannot change to another method without his consent'.* The provider advised the client to return with her husband, so that they could be advised and decide together on the best method for her in her situation.

Another client came to the same facility to use Depo Provera (an injectable contraceptive) after discussion with the provider. It was noticed that the client's husband had died two years ago and now she was dating another

man. The provider asked if the client had been tested for HIV/AIDS; the client replied no. The provider counselled the client and asked her to bring the man she was dating, so that they could be tested for HIV together. The reason for this advice was that the injection method prevents pregnancy only and not STIs and HIV/AIDS infections. The client agreed to bring her friend so that they could be counselled together before starting to use a contraceptive.

The providers from Musoma MC appeared to be stricter with required preconditions for a client to get contraceptives. To mention one difference with health workers from other LGAs: they did not take for granted the information given by the clients concerning the menstruation. Also, providers from two health facilities at Musoma MC sent some clients home without getting any family planning method, merely because they did not come with a personal identification number (ID) or they were not on menstruation. It was noticed that some of clients had already obtained the contraceptive from the same facility or from other facilities. Still they did not come with their ID number; either they had forgotten it at home or lost it. The providers explained to the clients that they should continue with the same ID number all the time and anywhere in the country whenever they visited a facility. When a client comes to the facility without her ID number she will be registered as a new client while in reality she is a recurrent client. So such clients were sent back home without receiving a contraceptive, to recover their ID number.

In Moshi MC a client friendly procedure was observed when a recurrent client came without her ID number. Here the provider opened a temporary file and filled in the client's information and requested the client to bring her identification number at her next visit. In Moshi DC still another procedure was observed. Recurrent clients who came without their ID numbers were given the provider's telephone number and requested to call in the ID when they reached home. The providers insisted that when you denied the client the services, she might become pregnant and loose the aim of family planning programme. Here it was also observed that a provider would send a client to the laboratory for a urinary pregnancy test (UPT) when in doubt about a possible pregnancy. In Moshi MC and Moshi DC the providers had been able to build a relationship of trust with clients. They had been working in the family planning units for such a long time that they knew most of the clients by name. This enabled the providers to offer contraceptive without even going to the side room to verify if the clients were on their menstruation.

In Musoma MC one client used injection since January (2014) and she had been waiting for her menstruation until June. She continued waiting until November (the day these observations were conducted) when she came to obtain a contraceptive. She told the provider she was on menstruation. The provider examined her and realised that she was not on menstruation and sent

her back home until she experienced the menstruation. The provider explained that some of the clients lie about being on menstruation, so they might be pregnant. One reason is the client might mistakenly assume that an eventual pregnancy could be terminated by using a chemical contraceptive. '*Or they may start saying I used the contraceptive but I got pregnant'*.

Another client in the same council had an appointment at a certain date, but showed up thirteen days late. The provider asked the client if she was on menstruation and the client replayed she was not. The provider then asked her why she did not come on the appointment day. The client insisted she forgot the date. The provider then, with a loud voice, told the client, *'Go home until you experience your menstruation'*. The client told the provider that after using the injection she took some time without experiencing menstrual bleeding, but the provider insisted, *'Go home until you experience your menstruation.'*

After dealing with the provider's level of training and the quality of services provided, the following sections will discuss the environmental factors that might affect the quality of services delivered. These factors include the availability of family planning methods, the working environments, working tools and relationship between provider, supervisor and co-worker. The last section that will be discussed is providers' coping strategy *(adaptation)* as course of programme implementation strategy.

8.5 Availability of family planning methods

For all clients to enjoy a choice among family planning options, a range of methods must be readily available. It is recognised that appropriate family planning methods for the clients differ according to their age, parity, marital status and family preference. Offering only a limited choice or lacking some of the family planning methods causes the clients to fail to choose the method that best suits their preference.

Availability of all contraceptives namely pills, injections, implants and IUCD was one of the major problems facing most of the facilities visited. This caused the facilities to lack the method mix, for the clients to have the wide range of choices for drugs as recommended by the guidelines. Moreover, a majority of providers were aware of all methods they should have had and displayed in their working table. However, only two facilities displayed the contraceptives available at their facilities: one from Moshi MC and another from Moshi DC.

Some of the providers hesitated to say openly that they experienced shortages of drugs, though their statements showed they lacked some of the contraceptives. A health provider from one health facility in Moshi DC justified this as follows:

'We do not have problem with the availability of drugs. Sometimes we experience a shortage of Implanon.' (P29: Health Provider)

As discussed in chapter 7, the strategy applied by providers to address this problem was borrowing the missing contraceptives from the neighbouring facilities and LGAs. Others counselled their clients to change the method they were using to an available contraceptive.

8.6 Working environment

Staff members of some of the facilities acknowledged that the poor quality of working environment negatively affected the provision of family planning services. Other facilities did not have any problem with working environment. In the facilities with a good working environment, the room was well arranged, with clients' files placed on a shelf for easy access when clients came in for family planning services.

The facilities that according to the health workers had a poor working environment, were equipped with a very small room. The room did not provide any privacy at all and most of the things were not arranged in good order. The clients' files were stashed in boxes, which made it difficult to look for a client file. Moreover, it was observed that the provider did not take any trouble to look for the client file in the boxes. When a client came in for the follow up services, the provider just recorded the client's name and the contraceptive received in 'Book no. 8'.[1] Recording the client information in Book no. 8 was mandatory since it was used for the monthly reports about the number of clients served and contraceptives used.

'The working area is not good at all: as the provision of family planning services requires to be provided in the privacy room. A room is required to have two people, client and provider without any disturbance from another person who uses the room for other activity. But in this facility we do not have the room for providing the family planning services. The room for family planning was that (showing the next room). The councillors came and discussed with facility in charge, and decided to change the use of that room and become the paediatric ward. This room was selected to provide CTC services and the family planning services remain without a room. Therefore, we were forced to use one room for CTC, antenatal services and immunisation services until they build another room.' (P30: Health Provider)

1. Book 8 is among 15 books in the Health Management Information System (HMIS) called Mfumo wa Taarifa za Uendeshaji Huduma za Afya (MTUHA) in Tanzania used to collect health data. This book is used to collect the family planning data in the facility.

Another provider commented that:

> *'I am not happy at all working in this room. The room do not have privacy, since there are no windows. Also there are contamination issues, because there is no washing sink. The room is congested in the way that even when you have sterilised equipment they just become contaminated since you do not have a place to put them.'* (P32: Health Provider)

In Kilimanjaro, each LGA had one health facility that had enough space and well-arranged rooms and another facility that had small room unarranged. In Mara region the facilities at Musoma MC had two rooms that were used to provide the family planning services, though they were not well arranged. Whereas, at Musoma DC the facilities visited had only one room that was used for all RCH services.

All facilities at Musoma MC had two rooms. The first room was used for consultation and the second one was used for medical procedures. The consultation room windows and doors were always open during the services provision. Someone sitting outside on the bench saw everything that happened inside and even heard the conversation. The procedure room had privacy and it was not easy to see what happened inside. In contrast, at Musoma DC the services were provided in one room while all windows and doors were open and what happened inside could be observed from outside. This room was used to provide other RCH services as well.

At Moshi MC observations were mixed. One facility was well arranged. The clients were entering in the room one after another and the door was closed which created a conducive environment and privacy. Another visited facility had a small room that was not well arranged. The clients' files were kept in boxes and all windows and doors were open all the time. The same was observed in Moshi DC where one facility followed all privacy protocols and another facility did not observe those protocols at all.

This caused the providers in the facilities where they did not have shelves to store the client files in boxes. Searching the client card in the box was difficult thus the provider often decided to serve the client without recoding the client information in the client card. The provider then just recorded the clients' information in Book no. 8. This practice caused the facility to lack the client medical records for future use if required or if the client develops any complication associated with the methods she had used.

Table 8.8 summarises the findings. The overview indicates that the LGAs from the Kilimanjaro region had a relative good working environment as compared to the LGAs from the Mara region. The total score for an LGA if all items observed were present is 12. To be able to rank the quality of the working environment, the interval was obtained by dividing the total points i.e 12 by four (4). Four reflect the number of LGAs and categories. The interval was used as a guide to rank the *quality* of the working environment

into four categories: (highest, high, low and lowest): 0-2 = lowest; 3-5 = low; 6-8 = high and 9-12 =highest.

Table 8.8: Working environment

Indicators	Moshi MC	Moshi DC	Musoma MC	Musoma DC
Large room	+ -	+ -	+ +	+ -
Privacy				
Windows have curtains	+ -	+ -	- -	- -
Door closed during consultation	+ -	+ -	- -	- -
Room well arranged with clients cards puts in shelves	+ -	+ -	+ -	- -
Presence of washing sink in the room	+ -	+ -	- -	- -
Room used for FP services only	+ +	+ +	+ +	- -
The LGAs *quality* in working environment	High	High	Low	Lowest

Note: The two symbols, + and -, indicate the presence or absence of the different items. Each sign represents one of the two facilities in the council, hence two signs for one council.

8.7 Working tools

Beside contraceptive drugs, a health provider should have some working tools that facilitate the provision of family planning. The working tools support the provider in helping and advising clients in accordance with the guidelines. The working tools/equipment that support provision of family planning examined were a spectrum, examination lamp, procedure bed, IUCD insertion kit and other supplies; gloves, gauze, syringes and lignocaine.

It was observed that the Moshi MC did not experience any shortages of equipment and other supplies. Its neighbour Moshi DC did experience a shortage of other supplies only. Musoma MC and Musoma DC had a shortage of both equipment and supplies. One provider from Musoma MC explained that family planning drugs were not supplied with other supplies (gloves, gauze, syringes and lignocaine). Normally these supplies were purchased from the facility budget. Shortages of these supplies caused the clients to go and buy them in the open market, so that they could obtain the family planning services.

'We have shortages of equipment, for instance those used to insert IUD are not enough. Also the implants are supplied without gloves, syringe, and lignocaine. The pharmacist or matron just say we have given you 24 implants while they do not include other equipment which goes hand to hand with implants… You find other equipment are not available at the

facility and that becomes clients' burden to go and purchase them.' (P26: Health Provider)

Other providers used the available materials even though it was not in compliance with the required standard procedure. As one provider from Moshi DC explained:

'We have a big problem on supplies: even currently we do not have gloves that is why you may see I am risking myself. I just wash my hand and inject lignocaine in the site I am inserting Jadele. Procedural I am required to wear two gloves. The first one been used when I am scrubbing the client inserting area and inject lignocaine. Then remove it and remain with the second one that I will insert with it the Jadele… Really we have severe shortage of other supplies, which accompany family planning like gloves, lignocaine, and gauze.' (P27: Health Provider)

Although there were some facilities that had a shortage of working tools, other facilities had extra equipment that they acquired from different donors that supported the facility. For instance, one of the health facilities at Moshi DC had a lot of equipment (even storing for others) received from EngenderHealth, Eggpuff and the Rotary club.

In one facility in Moshi MC it was observed that the brochure materials were kept outside in the waiting area, where any client could access them and pick them up at any time. However, there was not any information or instructions given to clients that they were allowed to pick up the brochure. This was different in another health facility in the same LGA where all brochure materials were kept at the provider desk. All clients, especially the new ones, were given these documents to read while the provider was explaining the client's method of choice. The client was encouraged to read about other methods when she reached home. This was observed in Moshi MC only; at Moshi DC, Musoma MC, and Musoma DC they did not have any brochures.

Generally, the same pattern that was observed concerning the working environment was found concerning working tools. The facilities from Kilimanjaro did far better in the availability of working tools and other supplies than the facilities from Mara region. The working tools quality was measured with five indicators that were examined across eight facilities in four LGAs. Each LGA had a possibility to score 10 if all items were present. Therefore, the interval between two scores (highest, high, low and lowest) was 2.5. The ranking for each LGA is shown in table 8.9.

Table 8.9: Working tools

Indicators	Moshi MC	Moshi DC	Musoma MC	Musoma DC
Spectrum	+ +	+ +	+ -	+ -
Examination lamp	+ +	+ +	+ -	- -
Procedure bed	+ +	+ +	+ -	+ -
IUD insertion set	+ +	+ +	+ -	- -
Other supplies	+ +	+ -	- -	+ -
Quality of working tools	Highest	Highest	Low	Low

Note: The two symbols, + and -, indicate the presence or absence of an item. Each symbol represents one of the two facilities in the council, hence two signs for one council.

8.8 Relationship between supervisors, providers and co-workers

Providers spontaneously reported that the relationship between provider and supervisor was very good *'when compared to previous days'*. The supervision process consisted mainly in mentoring and coaching and when there were any noticeable problems polite language was used to educate the subordinates.

> *'We have a very good relation with our supervisor in this council because they always use polite language if they observe any problem. They just tell us you should do like this like this. It happens one time the whole CHMT team come in this facility and we worked with them for some time. For instance, the DMO may come to spend one week in this facility working with us.'* (P30: Health Provider)

In some LGAs the providers noted that they had a very good cooperation and performed all activities in the family planning unit together with other staff, especially with those who were working in the RCH department. Yet for the workers who were deployed in other departments it was very rare to work in a family planning unit. This phenomenon was more pronounced and observed in the Kilimanjaro region than in the Mara region. In the latter region, the providers and the DRCHco acknowledged that they did not have someone permanently allocated in the family planning unit, due to shortage of staff. Therefore, anyone might be assigned to work at a family planning unit from time to time. One provider from Kilimanjaro put it as follows:

> *'Some of the workers fear of you, if you were not here all workers working in this department (RCH) they come to work in family planning unit as well. They think you're watching, so they do not want to be seen but other days we work in any unit. When there is a client who needs IUD is when they ask for help. They cannot insert IUD*

> *because it needs some expert to avoid perforation of uterus.'* (P27: Health Provider)

Another provider from Mara added that:

> *'Other providers from other department do not have any problem… In our facility we cooperate in all aspects even for me I may go to the ward and start providing the services when I do not have a client. The good thing for us nurses is that we have good cooperation. I may pass at reception area and find there are a lot of patients and that nurse working at that unit is overloaded: I will help her. So when I have a lot of clients and ask her for help she cannot refuse.'* (P31: Health Provider)

Even though the provider might request help from colleagues in other departments if she had too many clients, it had to be someone with some knowledge on family planning. Although all nurse midwives know something about contraceptives they might not possess expertise in long acting methods. So when a provider requested someone to help her, the task of the assistant typically would be limited to providing an injection or pills while the provider continued with recording the client's information.

8.9 Coping strategy (adaptation) of providers of family planning services

Street-level bureaucrats (providers) are important actors in the implementation process of family planning programme. They are the field-workers who are interacting directly with clients in implementing and delivering family planning commodities and services. A majority of these providers regard their work as a practical job distant from the territories of policy makers. A programme is nothing except paper until the providers have delivered this programme to the clients. These providers often have considerable discretion in performing their daily activities. Therefore, this section is examining coping strategies done by providers during the implementation of the programme.

It was noticed that providers developed certain strategies to cope with client overload and to restrict the number of clients they would serve. Some of the providers encouraged and even insisted the clients to use specific contraceptives more than others. For instance, one provider from Moshi DC said that she was encouraging clients to use long acting contraceptives with the aim of reducing the workload. Clients using a long acting contraceptive would not have to return to the facility for three years in the case of implants up to twelve years in the case of an IUCD. On the contrary, clients using short acting contraceptives would have to come back every three months for

another dose. Another motive noticed was to reduce the complications associated with certain contraceptives. As explained by one provider:

> *'I am encouraging the clients to use long acting methods because the clients who are using Depo have a lot of complaints for a long time. The clients using Depo always complain: you may in one week have four clients complaining about the same thing, so you realise there are problems. I decided to conduct research on these complaints. When you look at the instruction (she showed the vial) Depo contains 150mg and a woman gets four vials per year which means 600mg in a year. The Implanon contains 68mg that remains active for 3 years. Now I ask myself how come when you use Depo you get 600mg in your body per year while implant is only 68mg over three years. I concluded there is an overload of progesterone dosage when someone uses Depo and that it was the reason why most of clients who use Depo have a lot of complaints. I decided to counsel most of my clients to switch to a long acting method to minimise the side effect caused by Depo.'* (P27: Health Provider)

Sometimes a personal experience might affect the behaviour and the decision on the kind of contraceptive the health worker offers. This was evidenced by one provider from Moshi DC who experienced a problem with an injection that caused her to emphasise other contraceptives rather than injection.

> *'As I have told you I have a good example. I had used two doses of Depo when I was still in college. I developed oedema in different parts of my body and was diagnosis with Congenital Cardiac Failure (CCF), and renal failure. Clearly this was caused by the Depo I was using.'* (P27: Health Provider)

Another provider from Moshi DC at another health facility was inspiring the client to use the IUCD. She said that all health workers were using IUCD because did not have any hormone, therefore, did not have any side effects. She told the client if she had a chance she might ask all nurses in that facility or even another facility what methods did they use and she would realise that they were using the IUCD. The two scenarios above showed that the providers from Moshi DC used different strategies to make sure that the clients use more long acting methods than short acting methods. This corroborates with the findings presented in the previous section of this chapter.

The providers from Musoma MC used a different strategy. In order to cope with a lack of knowledge they encourage the clients to use more short acting methods. One provider from the same council said that she preferred her clients to use the short acting methods. In order to reduce the number of clients who were using injection, she was educating her clients on how they could hide the pills for their husbands. She claimed when she gave the clients

the pills to regulate their menses they could hide them and use it for one month. The motive for these providers was to restrict the clients from using long acting methods since they were not in capacity to provide the long-acting methods. As explained by one provider:

> *'We are delivering the services using experiences acquired at health facility. You can find someone had attended training since 2010 still she continues to provide the services. Myself I provide only the short acting methods. I do not provide IUD since I do not know how to insert it. I have never attended any training on provision of long acting methods.'* (P26: Health Provider)

Coping strategies were not only adopted by providers. Clients, too, developed practices that enabled them to use family planning services without the knowledge of their husbands. Most clients opted for an injection in order to be secret. In Musoma MC some clients left their ID numbers in the facility to be stored by the provider, so that the spouse could not find it and discover that his wife was using a contraceptive. One of the clients commented:

> *'For me the injection is easy method because my husband cannot understand if I am using family planning. After getting a dose is my secret I know the next dose will be that month. So I just come with my child as I am going to child clinic but in my soul I know I am going for family planning. I think if I use the Implants I may get the problem: because when I come to remove it may happen I do not find any nurse who is available at facility. Also when my husband sees the plaster in my arm will start asking what this for, but injection he does not understand what is going on.'* (P12: Client)

It was noticed that the personal experiences of the provider were one of the factors that made the provider emphasise a certain type of method more than others (adaptation). It could be that the health provider herself had a specific experience with a contraceptive, and it could also be that she had accumulated preferences from work experience. Another factor influencing the provider's approach consisted of her competences; the skills she had acquired from training attended. Providers without formal training in long acting methods tended to stress the use of short acting methods. Likewise, providers with formal training on long acting methods stressed on the use of long acting methods. Even though they were trained in all methods, they systematically preferred the long acting methods because it limited the work load. This was common in Kilimanjaro in all LGAs, where all providers had attended training on all methods. They more often counselled the clients to use long acting methods, while the providers in the Mara region encouraged their clients more to use short acting methods.

8.10 Concluding remarks

This chapter was written with the aim to describe how the health workers at health facilities convey family planning programme commodities and services to clients. The research data show that the LGAs from the Mara region had lower mean scores in all indicators of 'client care' and 'counselling and education' than the LGAs from Kilimanjaro. There were observed changes in the Mara LGAs where more clients used long acting methods than LGAs in Kilimanjaro. This might be attributed to a specific policy of the ministry and the NGOs' aimed at the Lake Zone. The providers from Kilimanjaro LGAs provided more long acting methods compared to their counterparts from Mara's LGAs. This might be contributed to the qualifications of the providers. At Kilimanjaro all health workers working at family planning unit had been trained to provide long acting and short acting methods. At the Mara region most health workers active in family planning had attended training on the provision of short acting methods only.

Also the chapter highlighted the differences in the working environment and availability of working tools. None of the LGAs in the Mara region did have sufficient working tools while in Kilimanjaro all LGAs were well provided with working tools. The Moshi MC and Moshi DC each had one facility with a good working environment and one facility without good working conditions. The facilities of the Musoma MC had good working conditions whilst the facilities in Musoma DC all had a deficient working environment.

Generally, the providers in the Kilimanjaro LGAs' facilities had a higher *dosage/exposure* of education and a higher *quality of services* provided than the workers of the Mara LGAs. The most obvious finding to emerge from this chapter is that there is a difference in *adherence* with procedures and standards that is reflected in the *quality* of family planning service provision across the LGAs. The *quality of services* provision is highest in Moshi DC; followed by Moshi municipal council, Musoma DC and the last LGA was Musoma MC. Although, the Musoma DC was the LGA that had the highest *programme reach* followed by Moshi MC and Musoma MC while the last one was Moshi DC. The specific experiences and competences of a provider caused her to have a specific coping strategy as an *adaptation* in the provision of the family planning services.

Chapter 9

Clients' responsiveness towards the family planning programme

9.1 Introduction

The previous chapters showed how implementers from different levels, from the ministry level to facility level, implemented the family planning programme. In this chapter the aim is to clarify the client's responsiveness towards this programme. A positive reaction of the clients is a prerequisite for the programme to realise its targets. Therefore, this chapter tries to answer one key question: what is the client's responsiveness towards the family planning programme?

In chapter 3 'responsiveness' was operationalised as 'the level of acceptance, awareness of different contraceptives and their usage, and satisfaction'. For this study data were collected in family planning units of health facilities amongst clients who already had decided to use contraceptives. Therefore, the measurement of 'responsiveness' had to be reduced to 'satisfaction with services received' and 'level of awareness of contraceptives and their usage'.

The clients' satisfaction was split into three areas: satisfaction with *conditions*, with *services received*, and with *waiting time*. Before discussing the client's satisfaction and level of awareness and usage the chapter starts with client's characteristics, client's reasons for using the facilities, their sources of family planning information and the content of received information. These antecedent circumstances are discussed because they may have a bearing on the way the clients approach the family planning services.

Most of the data used to assess the client's responsiveness were collected from the interviews conducted with a sample of clients. They were asked to narrate their story concerning their experiences with the services received. Additional information was used from observation to substantiate with the information given by the clients.

9.2 Demographic characteristics of the respondents

Table 9.1 shows that a total of 24 clients were interviewed, at least four clients in each of the LGAs involved in the research. In all four LGAs a majority of clients were married. The highest education level was primary education for the majority of the clients in Musoma MC and Musoma DC. A large portion of the clients from Moshi MC and Moshi DC had secondary educa-

tion and above. Also, most of the clients in the sample were aged between 30-39 years, with the exception of the Moshi MC where the majority was aged between 19 and 29 years. Differences were observed in the clients' number of children and in their occupation. A majority of the clients in Moshi MC and Moshi DC had three children at most while most of the clients from Musoma MC and Musoma DC had more than four children. In Moshi MC and Moshi DC more clients were engaged in income generating activities than in Musoma MC and Musoma DC. Clients from the latter LGAs were either housewives or peasants.

Table 9.1: Respondent characteristics

	Moshi MC		**Moshi DC**		**Musoma MC**		**Musoma DC**		**Total**	
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Age										
19-29 years	5	55.6	0	0	2	33.3	1	25.0	8	33.3
30-39 years	3	33.3	4	80.0	3	50.0	3	75.0	13	54.2
Above 40 years	1	11.1	1	20.0	1	16.7	0	0	3	12.4
Marital status										
Married	6	66.7	5	100	5	83.3	3	75.0	19	79.2
Single	3	33.3	0	0	0	0	0	0	3	12.5
Widow	0	0	0	0	1	16.7	1	25.5	2	8.3
Highest education level										
No education	0	0	0	0	0	0	1	25.0	2	8.3
Primary education	4	44.4	2	40.0	4	66.7	3	75.0	13	54.2
Secondary education	4	44.4	2	40.0	2	33.3	0	0	7	29.2
Bachelor education	1	11.1	1	20.0	0	0	0	0	2	8.3
Number of children										
Does not have child	2	22.2	0	0	0	0	0	0	2	8.3
1-3 children	6	66.7	4	80.0	2	33.3	1	25.0	13	54.2
4 and above	1	11.1	1	20.0	4	66.7	3	75.0	9	37.5
Occupation										
Housewife/peasant	3	33.3	1	20.0	3	50.0	4	100	11	45.8
Small business	5	55.6	3	60.0	1	16.7	0	0	9	37.5
Profession (teacher, tailoring and counsellor)	1	11.1	1	20.0	2	33.3	0	0	4	16.7
Total clients in each LGA	9	37.5	5	20.8	6	25.0	4	16.7	24	

The table presents the characteristics of clients interviewed. All clients interviewed were women; there were no women who were accompanied by a husband/partner.

Table 9.1 indicates that the clients at Moshi MC and Moshi DC were more educated and had better occupations than those of the other two councils. Good education and good jobs foster intrinsic motivation for family planning. These women had an incentive to space their children so that they could manage to raise their children and have time left to work as well. A client from Moshi DC formulated it as follows:

> *'Life has become very difficult; children need food, education and clothes. Currently I have three children. The process of raising and educating them is very difficult. So I have decided to use a contraceptive until they are grown up. If we agree to have another child later, we will decide.'* (P14: Client 3)

A positive attitude towards family planning, as expressed by clients in interviews, tended to further the utilisation of contraceptives. For some clients, intrinsic motivation was more important to turn to a family planning service facility than the promotion of the programme.

9.3 Reasons for using the facility

Generally, residing close to a facility and the *quality of services* offered were the most often mentioned reason for the clients to use a facility. A few exceptions, clients that were not using the nearest facility, were noticed during observation. These clients were willing to walk a little bit further to seek better services. A client from Moshi MC told us:

> *'I am using this facility because it is close to where I live: but more importantly it is the quality of services offered. If the services in this facility were not good I would have decided to go to another facility. Nowadays even dispensaries provide these services. Although you may go to a dispensary and risk being injected with a drug that has expired and become pregnant. Since I have trust in the services provided in this facility I do not see a need to go to another facility even if it is more close to where I live.'* (P9: Client 2)

The experience of good quality treatment received when giving birth turned out to be a motivating factor for the clients to obtain contraceptives from the same health facility. The following statement illustrates the reason for using the facility:

> *'It is very close to where I live and when I came for delivery they handled me very well, so I decided to come here (for contraceptives) since I believe is a good facility. I used this facility when I was sick, and for delivery… when you go to a facility and get a good warm*

> *welcome together with good services you will go there again.'* (P5: Client)

Other clients were referred to a facility by their relatives and friends. It was not unusual for clients to start a conversation with friends and relatives and discuss contraceptive methods and seek advice on the facility they should use. As explained by one clients from Moshi MC:

> *'I have known this facility through my sister. She told me about the risk of getting pregnant, and the option of going for an abortion and she told me that the family planning would be a good option. So, when I asked my friend which facility offers good family planning services she recommended to me to this facility.'* (P18: Client)

In summing up, primarily residing close to a facility and *quality* of services were the reasons for clients to use the facility. In addition, the *quality of programme* itself was a reason for clients to use the facility, often after they had been assured by their relatives and friends that the facility offered good family planning services. The way the programme was delivered stimulated clients to use the services again and to refer the facility to their colleagues and friends. With this regards the clients responded to the programme positively after knowing that a certain facility provided *quality services.*

9.4 Sources of family planning information and the content of the information received

Clients from seven facilities out of eight claimed that the providers were too busy and did not have sufficient time to be informed properly about contraceptive methods and family planning. This made them more dependent on their friends and relatives to acquire information concerning contraceptives. The clients discussed the advantages and disadvantages of different contraceptives with their friends and relatives and gained information on the side effects associated with different family planning methods. They were told what methods to use to avoid problems. The discussions covered all methods, from injection and implants to IUCD. In Kilimanjaro the clients had been discussing long acting methods more than short acting methods while at Mara the information shared was mostly about the short acting method (injection). This information coincides with the findings in chapter 8 where we noticed that long acting methods were used relatively more in Kilimanjaro region than in Mara region.

In addition, the clients from Kilimanjaro region were more informed than the clients from Mara region. This might be traced back to the historical background of family planning in Tanzania. The Ministry of Health and So-

cial Welfare-Reproductive and Child Health section website[1] explained this concern in detail.

The family planning programme was initiated by 'UMATI in 1959 in selected urban centres of Tanzania mainland, namely Dar es Salaam, Morogoro, Mwanza and Moshi'. Since the initiation of the family planning programme in 1959, it took fifteen years to roll out the services all over Tanzania. The programme waited for another fifteen years before it was officially launched in 1989. The Reproductive and Child Health Section was established in 1997. Moshi was one of the early adopters of the programme and started it right in 1959. Thus, these clients had been exposed to family planning information for about thirty years, way ahead of clients in other LGAs and in other regions such as Dar es Salaam, Morogoro, and Mwanza.

Because the health workers did not have the time to give adequate information the clients turned to their relatives and friends and as a result the majority of clients came to the facilities after having made a decision on which contraceptive they would use. One client from Musoma MC said she went to the facility to seek some clarifications but she was welcomed in such an unfriendly way that she became afraid and went back home without asking. She said that:

> *'I was planning to ask the provider what happens when someone uses injections and does not experience menstruation: is there any side effect I may get and is there anything I can do to have a normal menstruation. But I did not ask that because there was no welcoming face, she was not cooperative and she was busy with her phone.'* (P 4: Client 1)

Another client from Moshi DC came to the facility to change her method from implants to IUCD. She had received information from friends that the IUCD was a method without any side effects because it did not employ the use of hormones. However, after a long discussion with the health worker (who happened to be a trainer for other providers, too) she decided to continue with the method she was using.

> *'Sometimes when we arrive at the facility they are so busy. When you ask the nurse she may harass you. There is no family planning method which does not have problems except IUD. I was not informed well about it at the facility. I got this information from my friend who is using IUD and says she does not have any problems.'* (P 7: Client 2)

In one facility from Moshi DC it was observed that the provider advised a client who did not want any more children to use the IUCD method. The

2. http://www.rchs.go.tz/index.php/en/about-rchs.html

client refused and said that she had heard from her friend that the IUCD had a wire that could be felt by her husband during intercourse. Also, she said it might go inside during intercourse. Therefore, the client refused the IUCD and opted for the injection method. Another client in the same council but at a different facility was being informed about all the different methods available, about their advantages and disadvantages. Still the client said that, *'I have heard from you about all methods but still I want implants. This is the method I had planned to use.'*

To summarise, health providers were as a rule very busy and do not have time to attend to all clients or provide them with the necessary information. As a result, clients turn to their relatives and friends for information concerning contraceptives. Consequently, when they do visit the facility to obtain contraceptives, they have already made up their mind on which method to use.

9.5 Client Satisfaction

9.5.1 General

Client satisfaction is one of the indicators used to gauge the quality of services delivery, as it gives information on the provider's achievement at meeting clients' expectations. Examining clients' satisfaction means identifying what clients want as opposed to what the health worker who delivers services assumes the clients want. The material from the research allowed the clients' satisfaction to be grouped into two main categories, *satisfied* and *dissatisfied*. The following sections will discuss client satisfaction with services received and with waiting time. However, prior to that, a section is devoted to a condition for treatment that was practiced by providers from one council and that led to dissatisfaction with some clients.

9.5.2 Conditions to be fulfilled by clients

The family planning procedure manual requires the provider, during a family planning session, to make sure that the client is not pregnant. After all, the aim of family planning is to avoid pregnancy. A pregnant woman should not use contraceptives. Worse, inserting an IUCD into the uterus of a pregnant client can lead to a septic miscarriage that has serious complications. In order to rule out that the client is pregnant the provider is required to ask the client the six questions of the Pregnancy Screening Checklist stipulated in the procedure manual.

During the observations it turned out that many health workers went much further in establishing that the client was not pregnant and required her to demonstrate she was in menstruation. This practice was not found in the

facilities of other LGAs. If in any of those facilities the health workers were in doubt about the possible pregnancy of a client, the client would be sent to laboratory for pregnancy test.

The clients were unhappy when sent back home without getting contraceptives simply because they were not in menses. Some were leaving the room talking by themselves blaming the provider; others continued talking in the facility corridor while they were on the way back home. So, going back home without getting a contraceptive dissatisfied most of clients and put them in risk of becoming pregnant.

9.5.3 Satisfaction with services received

Ideally 'informed choice' refers to the norm that the client makes her decisions concerning contraceptive use herself, on the basis of adequate information provided by the health provider. The providers are required to support these clients through health education, explaining the available family planning methods and their advantages and disadvantages. After that the clients are capable of comparing the advantages and disadvantages of different family planning options against her choice and to choose the method that fulfils her needs. Once a client has selected a family planning method she will want the provider to explain to her how to use the method safely and efficiently. This information is supposed to be shared with new clients. Likewise, for follow up clients the health workers might restate the information given to clients when they start the methods for reinforcement.

However, a majority of providers in all LGAs did ask the client which method she would like to use. After that, some of them explained to the client the advantages and disadvantages of the method indicated by the client. Others just provided the method to the client without any explanation concerning the available methods or even the selected method.

It was found that half of the clients of the Kilimanjaro health facilities were satisfied with the services they had received. The clients were satisfied with explanations given about methods selected and with the way providers performed the procedure. They went further by saying they even did not feel any pain while the implants and IUCDs were inserted. Another aspect clients were satisfied with was the room arrangement. The room had privacy so the people outside did not hear what was happening inside. '*What impresses me is the service I have received. I am so happy because I receive what I wanted'*. Other elements in the behaviour of the health workers that were appreciated by clients: the language used by provider and the fact that the client had been served well without being required to give any bribe. As put by one client:

'Mostly we were afraid to come for family planning because we think nurses use harsh language but she was good. You know I am not used to public facilities. I was going to a private hospital for my first birth to be far from nurses who are believed to be rude, but when I decided to attend here they did not have a problem. One is the service I received, and I was not threatened as I was expecting. Also the good information given and good welcoming. But I was told when you go to an antenatal and postnatal clinic you will be told about contraceptives even though you do not want to use them. I have attended the clinic more than one year and I never got such education until I searched for it. It is possible that other clients do not know as much as I do. I have studied until university level but I was not aware of how an IUD is inserted until I used it. Today I understand. We see announcements on TV but without details. The details will be found at health facility.' (P14: Client)

The clients in Musoma MC and Musoma DC were more dissatisfied with services received than their counterparts from Moshi MC and Moshi DC. They claimed that they were not given any health education on family planning and on the advantages and disadvantages of the available contraceptives. Although they were led to believe that they would receive such information. They also said that some of the providers were only explaining the method they had selected to use. Other clients were told to read the posters in the wall. As one client put it:

'I just read the poster and she tells me to select the method that I want. I was not given any additional explanation. .To be honest I was not given any education on family planning. I do not know anything about family planning; I am just using it, with the little knowledge I have from friends. I just come here and get an injection and return back home. Even the first day I just read the poster and she asked me what method I wanted. I told her injection and she just gave me the injection.' (P15: Client 3).

Another client added that:

'When you come up here you just show the card and the provider injects you and off you go: simply because you have already registered and provided your information during the first visit.' (P12: Client 3)

One client from Moshi MC said that when they came and found the students who were on a practical training session, they were checked all vital sign such as body weight and blood pressure. But when they came for a follow up and found the usual provider their vital signs were not checked, which dissatisfied them. The clients were aware that one of consequences associated with contraceptives is body weight gaining and increasing blood pressure. There-

fore, they were eager to know their body weight status. It was observed that the checking of vital sign was done in two facilities in Kilimanjaro region; one from each LGA (Majengo and Himo health centres), while in Mara region it was rarely done in any of the LGA facilities.

Another client from Musoma MC claimed that she received family planning education a long time ago (in 1992), so she was expecting to be given new information. She assumed there had been a lot of updates as far as family planning was concerned. She had been willing even to change the method she was using if she was given enough information on available methods. A client from Moshi DC added that she had used contraceptives for a long time but she never got information or explanations whenever she went to facility. In her own words:

> *'Really since I started using family planning a long time ago I have never gotten any information on advantages, disadvantages and effectiveness of the methods. When I came here I just received the methods and left. I have not been told how it works when it is injected into the body. When you are told how it works you will be confident with what you are using. You will know when something happening is normal or whether I should not do this or that. What I can say when I came here I found them busy and they provided a contraceptive in a hurry. For instance, the nurse may come up to you in a hurry and give you the contraceptive and then move on to another activity. She did not take the time to sit down with you and discuss family planning.'* (P 3: Client 1)

The client's arguments match observations made during fieldwork at one of the facilities at Moshi DC. The provider was running two clinics: a family planning clinic and a Care and Treatment Clinic (CTC). This forced her to rush back and forth and she failed to spend enough time with clients. One day, three clients came to switch from injection to implants. The provider did not ask anything or give any information or advice. She merely put a record into Book 8 and inserted the implants.

The providers themselves admitted that they failed to provide the services as required by the guidelines since they had multiple tasks. This caused them to lose concentration with family planning service provision and with clients at large. The phenomenon was observed primarily in all the facilities without a health worker who was permanently assigned to the family planning unit. As provider put it:

> *'When someone is allocated to this unit the concentration is very low. This is different from someone who is assigned permanently in this unit. If you are permanent in this unit, since arrival in the morning you can plan today I will do this and you will have ample time to talk with clients. But currently you may talk with one client, then you leave and go to the la-*

bour ward to assist women to give birth. When you come back you find other clients have left the facility without been attended. Even when you come back your concentration is already disturbed: you're not the same as when you started the service. You start again afresh to gain momentum but you may stay for a short time and be called again to another unit to provide services.' (P26: Health Provider)

As shown in table 9.2 the clients from Musoma MC and Musoma DC were more dissatisfied than the clients from Moshi MC and Moshi DC.

Table 9.2: Satisfaction with services received

Indicators	Moshi MC	Moshi DC	Musoma MC	Musoma DC
Explanation given	+ -	+ -	+ -	+ -
Room arrangement	+ -	+ -	+ -	- -
Room privacy	+ -	+ -	+ -	- -
Language used by provider	+ +	+ +	+ -	+ +
Checked vital sign	+ -	+ -	- -	- -
Clients responsiveness	High	High	Low	Low

Note: The two symbols, + and -, indicate 'satisfied' and 'dissatisfied'. Each symbol represents one of the two facilities in the council, hence two signs for one council. Thus the maximum number of '+' or '-' that any LGA may acquire is ten.

9.5.4 Satisfaction with waiting time

The clients of those facilities that had workers permanently assigned to the family planning unit did not have problems if they had to wait, provided they were getting the good services. Clients said that they did not care for how long they waited until they received the services. However, some of the clients pointed out that the waiting time might be reduced if the number of providers who provided the family planning services were increased. It was observed in one facility that the services were provided by one provider only. When there were new clients who required time to decide which method to use, others had to wait for a long time as explained by one client:

'I arrived here at 12:00 noon and found queue also there were about 3 new clients who were starting the service. So, I cannot complain because everyone has right to get services according to the time she arrived to the facility. We cannot say because you are a new client you spend more time let us go first. I remain in queue waiting my turn that is normal. No problem because if I had come early also, others will wait for me, the other clients who came after me even if they're in hurry they should be patient and wait because they are in need of services.' (P 9: Client)

Clients tended to be dissatisfied about waiting in facilities without a provider who was permanently assigned to the family planning unit. They complained that they did not have any option since when they arrived at the facility they found the nurses were engaged in other activities. Therefore, they had to wait until the nurse(s) had finished what they were doing and to come and serve them. The following statement was provided with one client showing in some facilities they waited for a long time without receiving the services.

> *'We always wait for long time in this facility before getting services. When you come here early in the morning they are still mopping: so they do not provide the services. For instance, today I stayed at home doing my activities knowing that when I come this time I will get services quickly and go back home without anyone noticing what I have come to do in the facility. But I have spent more than two hours waiting for them they are just doing other activities inside.'* (P 8: Client 2)

Another client from Musoma MC elaborated that sometimes she had to wait for the provider hoping she would come to serve her, but she might stay for the whole day without seeing anyone.

> *'We get a lot of trouble to find someone to tell us where the provider has gone. Even those I found at facility they told me that they come here on Friday, the room was closed they stayed here from 9:00AM until 2:00PM and they were told to come on Monday. When they came on Monday they stay again until 2:00PM and been told to come yesterday. Yesterday I joined them because it was my date to come for a second dose, but I did not get the service. I arrived at the facility at 9:00AM and left 11:00AM without getting the services. Yesterday the office was open and when we asked for the service provider we were told she has gone for tea break.' (The day of interview was Wednesday)* (P10: Client 2)

In one facility in Moshi DC it was observed that the health worker started her day working in the Care and Treatment Clinic (CTC) before moving to the family planning clinic. She started providing the family planning services at 11:05AM. After providing the service to the first client the provider left the room to do another activity. She returned again at 12:48 PM to attend the remaining clients. When she left the room the first time clients were still waiting and she told them to wait for a moment she would return to attend them.

One client from Musoma DC said that she was acquainted with the provider who was taking care of the family planning services. So when she arrived at the facility she just looked for the provider and asked her to come into the family planning provision room. She always did that to avoid staying

in the facility for a long time since she was using the services without the knowledge of her husband.

Generally, the waiting itself was not the cause of dissatisfaction, but waiting without knowing for how long dissatisfied the clients. Clients from one facility in Musoma MC told that they had waited for three consecutive days thinking the provider would come while in reality the provider was not available. A summary of these findings across councils is presented in table 9.3.

Table 9.3: Satisfaction with waiting time

Indicators	**Moshi MC**	**Moshi DC**	**Musoma MC**	**Musoma DC**
Satisfied	+ +	+ -	+ -	+ -
Found the provider in the room	+ +	+ -	+ -	+ -
Client responsiveness	Highest	Low	Low	Low

Note: The two symbols, + and -, indicate 'satisfied' and 'dissatisfied'. Each symbol represents one of the two facilities in the council, hence two signs for one council. Thus the maximum number of '+' of '-' that any LGA may acquire is ten.

9.6 Client awareness of contraceptives and their usage

Clients exhibited different level of awareness and fallacies about family planning methods as a result of the fact that they relied on their friends and relatives for information. These fallacies related to all methods, pills, implants and IUCD. Clients were usually well-informed about the injection method. Some of the clients thought pills would accumulate in the stomach and cause cancer. Others had the idea that implants, once inserted in the arm, would shift from one place to another. Another mistaken belief was that the IUCD caused wounds in the uterus, or that the child might be born wearing it in the neck. Others believed the IUD caused fungus. These fallacies were found equally in all LGAs. Yet, the clients from Musoma MC and Musoma DC had more misconceptions.

One of the advantages/disadvantages of an injection is scanty menses or *amenorrhea.* Clients interpreted the failure to experience menstruation as a 'concealment' of the blood inside the uterus. They expected the concealed blood to cause problems in the future. As a consequence, the clients after using the injection, waited until they experienced menstruation and then returned for a next dose. This belief was shared among a majority of the clients from Mara region in all LGAs. As explained by one client:

> *'I was experiencing back pain and when I told my friends they told me were the effect of postponed menstruation. I came here (health facility) and they told me that the back pain was not caused by the contraceptive I*

was using. Although I was advised by the doctor to stop using an injection.' (P16: Client 3)

This false notion was not only entertained by clients but by the RCHco, DRCHco Health Secretaries and providers as well. In the Mara region they claimed that the clients had a lot of misconceptions to be addressed. They went further, elaborating that there was more misunderstanding among men than among women. That was one reason for their wives to use contraceptives secretly. One of the providers reported that:

'Most of the people are saying these drugs cause cancer: others are saying when you use more injection is when you can get cancer. Others believe pills accumulate in the uterus and cause problems; or you may give birth to a disabled child. What I could say is that there are a lot of rumours going around in the community concerning contraceptives.' (P31: Health Provider)

In the same vein, one provider from Moshi DC said that the injection was not good for the young women and older women:

'Nowadays they are saying the Depo-Provera (Injection brand) will be removed from the accepted contraceptives list. They have done research and realised that it is not good. Especially for those women who are still in the process of continuing giving birth or those who have many children. They advise them to use other methods instead of Depo. We were given this information by some of the facilitators during training.' (P28: Health Provider)

This showed that misconceptions about contraceptives were not only found among the clients but also among the providers. Some of the clients from Moshi DC and Musoma MC said that the health providers, especially the doctors, told them that contraceptives were not good for their health and if possible they should avoid them.

'You know we live together with nurses and doctors in one street and they always tell us these drugs are not good. We use them only because we want people to plan their births.' (P 7: Client 2)

Table 9.4 illustrates that the clients from Moshi MC and Moshi DC had the highest and most moderate client responsiveness respectively. This was caused with the fact that the clients from this council had relative high level of awareness that lead to less fallacy concern contraceptives. For the clients

from Musoma MC and Musoma DC had a low level of responsiveness. This has contributed to a low level of awareness and a high prevalence of fallacies.

Table 9.4: Clients awareness of contraceptives

Indicators	Moshi MC	Moshi DC	Musoma MC	Musoma DC
Level of awareness	+ +	+ -	- -	- -
Fallacies	- -	+ -	+ +	+ +
Client responsiveness	Highest	Moderate	Low	Low

Note: the two symbols, + and -, indicate the presence or absence of fallacies and the level of awareness (high or low). Each symbol represents one of the two facilities in the council, hence two signs for one council.

9.7 Concluding remarks

This chapter provides insights into clients' responsiveness towards the family planning programme. The clients from Moshi MC and Moshi DC had both programme related factors and an intrinsic motivation towards the family planning programme. This was contrary to clients from Musoma MC and Musoma DC.

The clients who received services in the facilities that had workers permanently assigned to the family planning unit were satisfied with the services received and waiting time. As they were assured that there was someone inside providing the services. These facilities were from Moshi MC and from Moshi DC. For those clients receiving the services in the facilities that did not have workers permanently assigned to the family planning unit were dissatisfied. This was at Musoma MC and Musoma DC.

Likewise, most of the clients received information concerning family planning more from relatives and friends than from the services providers. One pinpointed reason was that the health workers had multiple tasks that caused them to have less time to spend with clients. The clients at Musoma MC and Musoma DC had more fallacy on contraceptives than their counterpart from Moshi MC and Moshi DC.

A summary of the data presented in this chapter is given in table 9.5. It shows that Moshi MC had the highest level of client responsiveness followed by Moshi DC, Musoma MC. The lowest responsiveness was found in Musoma DC.

Table 9.5: Summary of clients' responsiveness across health facilities

LGAs	Health facility	Clients responsiveness
Moshi MC	Majengo HC	Highest
	Pasua HC	Highest
Moshi DC	Kiruwa Vunjo HC	High
	Himo OPD	Highest
Musoma MC	Nyasho HC	Moderate
	Bweri HC	Low
Musoma DC	Murangi HC	Moderate
	Suguti Disp	Lowest

Chapter 10

Discussion, conclusion and recommendations

10.1 Introduction

The purpose of this study is to see to what extent geographical differences in CPR can be attributed to differences in the way the regions and local authorities implement family planning policies. The central research question for this study was: How is Tanzania's national family planning programme implemented, and can differences in implementation practices explain differences in CPR?

In order to answer this question, the implementation practices in four LGAs were compared on seven properties of programme implementation, namely implementation fidelity *(exposure/dosage, adherence, quality of delivery), participant responsiveness, programme reach, adaptation* and *monitoring and control conditions.* These properties were examined across different levels of programme implementation starting from the ministerial level, at the Ministry of Health and Social Welfare, all the way down to the client's level.

The main thrust of this chapter is to discuss whether differences in implementation practices have an impact on CPR. The general proposition of the whole study is: the better the implementation practices, the higher the CPR. In this chapter the collected data will be analysed to see whether predicted patterns do indeed fit reality. The discussion of the results begins with examining and discussing whether client responsiveness influences the CPR. Then the implementation fidelity across health facilities will be discussed. It was hypothesised that differences in facility implementation fidelity can be explained by the differences in planning across LGAs. The variation in actual implementation practices in the field in relation to LGAs planning will be analysed as well. The proposition here is: the better the planning of the LGA, the more implementation fidelity across the LGAs and the facilities. Further, review of the central implementation fidelity (*adherence, exposure/dosage and monitoring of the control*) between the central government and the LGAs was done to ascertain whether it influences the observed differences in CPR of the LGAs. The effect of *Zonal Health Resource Centres* (ZHRC), NGOs and Roman Catholic organisations on observed CPR differences across LGAs is another area discussed in this chapter. The chapter ends with a conclusion and some recommendations to increase the utilisation of family planning services and eventually CPR.

As discussed in chapter 4, the selection of the units of analysis was based on the distribution of CPR: the Kilimanjaro region had the highest CPR (above national average) and the Mara region had the lowest CPR (below national average). Likewise, four LGAs, two from each region, were selected. The selection of the LGAs was based on the CPR. From each region the LGA with the highest and the lowest CPR was selected. Thus, the Moshi MC and Moshi DC had the highest CPR, whilst Musoma MC and Musoma DC had the lowest CPR.

Figure 10.1a: Model provide an overview findings of the actual implementation of family planning programme

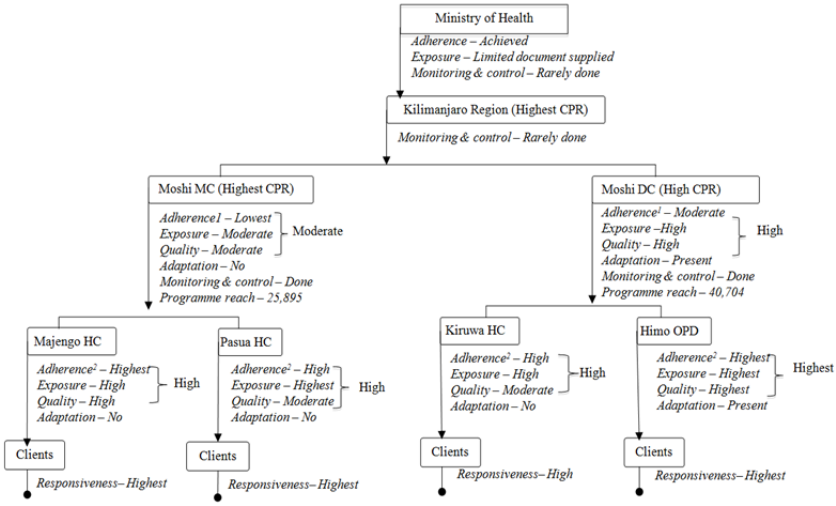
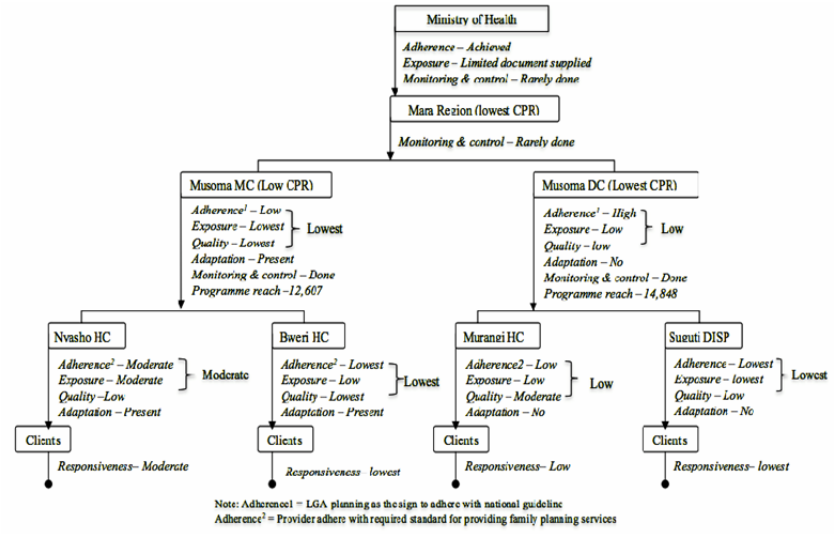


Figure 10.1a and 10.1b show a summary of the findings on the seven implementation properties across the study's units of analysis. The figures show the similarities and differences of these properties across the studied health facilities, LGAs and regions. The figures will be used as the basis for the discussion in this chapter. Originally, in chapter 3 *programme reach* was operationalised as realisation of predetermined targets. During data collection it turned out that there were no target numbers specified in any of the LGAs and health facilities. Therefore, the operational variable to measure the *programme reach* was changed to the analysis of the actual number of clients reached together with the availability of programme documents at LGAs and health facilities. The reason for this change was that there were not any local authorities that had written targets on family planning programme in the financial year 2013/2014. The observation in eight health facilities was done

with the aim to contribute to the explanation of the differences in CPR across the LGAs.

Figure 10.1b: Model provide an overview findings of the actual implementation of family planning programme



10.2 Clients' responsiveness and CPR

The clients' responsiveness denotes how far clients respond to, or are engaged in family planning programme. It involves an assessment by the clients of the benefits they gained from the programme, the experience they had and the information they heard concerning family planning and what to expect from the health facility in that area. The clients' responsiveness was not analysed in its full meaning; that is analysing a change in behaviour. Instead the study assessed the clients' awareness of different available methods and satisfaction with services received from providers. The proposition was that a certain level of clients' responsiveness would correspond with a certain level of CPR. The purpose of this section, therefore, is to assess whether such a correspondence can be found and whether the predicted pattern is reflected in the actual implementation experience. The predicted pattern is the highlighted matrix diagonal in the tables that will be used in the following sections.

The available CPR data were at the level of the LGA. Therefore, to be able to predict the pattern between clients' responsiveness and CPR, the clients' responsiveness at facilities level was aggregated to LGA level. Moreover, the CPR was divided in four classifications (highest, high, low and lowest) and the aggregated clients' responsiveness was given the same classifications.

Table 10.1 confirms the proposition. All of the four LGAs, Moshi MC, Moshi DC, Musoma MC and Musoma DC fit the predicted pattern. According to these data, we can infer that the clients' responsiveness is one of the factors that contribute to the geographic differences in CPR.

Table 10.1: Predicted and actual pattern between LGAs clients' responsiveness and CPR

		LGAs client responsiveness			
		Highest	High	Low	Lowest
CPR	Highest	Moshi MC			
	High		Moshi DC		
	Low			Musoma MC	
	Lowest				Musoma DC

As elaborated upon whilst developing the conceptual model in chapter 3, CPR is an outcome of a programme implementation process that is affected by clients' responsiveness and by implementation fidelity. It is assumed that the clients' responsiveness is influenced by implementation fidelity. Hypothetically implementation fidelity influences clients' responsiveness and clients' responsiveness influences the CPR. Besides that, the implementation fidelity might have a direct effect on the CPR. Thus, the following sections will analyse and discuss predicted patterns of relations between implementation fidelity and CPR.

10.3 Facilities' implementation practices

10.3.1 LGA implementation fidelity and CPR

The purpose of this section is to analyse to what extent the LGAs' implementation fidelity contributes to explaining the differences in CPR across the LGAs. The LGA implementation fidelity was obtained by aggregating the facility implementation fidelity to the level of the LGA. For instance, the Nyasho health centre with moderate implementation fidelity and Bweri health centre with lowest implementation fidelity were aggregated to low implementation fidelity for the Musoma MC. On the basis of these aggregates, a predicted pattern between implementation fidelity and CPR was compared with the actual distribution.

Table 10.2: Predicted and actual pattern between aggregated LGAs implementation fidelity and CPR

		LGA implementation fidelity			
		Highest	High	Low	Lowest
CPR	Highest		Moshi MC		
	High		Moshi DC		
	Low			Musoma MC	
	Lowest				Musoma DC

The result in table 10.2 shows that the implementation fidelity corresponds to a large extent with the observed geographical differences in CPR. Moshi DC, Musoma MC and Musoma DC clearly follow the predicted pattern: high implementation fidelity corresponds with high CPR and low implementation fidelity with low CPR. One LGA, Moshi MC, does not follow the pattern entirely but this can be explained as follows. Moshi MC showed high implementation fidelity (not the highest), but had the highest CPR. This inconsistency may be due to differences in *client' responsiveness*, and the *quality* of services delivered.

The possible explanation goes back to a notion already mentioned in chapter 2: socioeconomic factors have a bearing on contraceptive use. Nationwide studies show that women with high socioeconomic status are more likely to use contraceptives. It was observed in chapter 8 that the clients from Moshi MC and Moshi DC on average had a higher level of education than those from Musoma MC and Musoma DC and that they more often were involved in small business or professional work. It had stimulated these women to use family planning in order to space their children and thus to acquire time to be engaged in income generating activities. Therefore, differences in socioeconomic status partially match the differences in CPR. Thus the client responsiveness in Moshi municipal can be high even though the implementation fidelity is not the highest.

10.3.2 Facility implementation fidelity and client responsiveness

After analysing the extent to which the implementation fidelity of facilities in the LGAs contributes to the differences in CPR across the LGAs, now a further analysis of the pattern between clients' responsiveness and facilities implementation fidelity will be carried out. The aim is to assess whether the same pattern can be established.

Table 10.3: Relationship between facility implementation fidelity and client responsiveness

		Facilities implementation fidelity				
		Highest	High	Moderate	Low	Lowest
Clients responsiveness	Highest	Himo OPD	Majengo and Pasua HC			
	High		Kiruwa Vunjo HC			
	Moderate			Nyasho HC		
	Low				Murangi HC	
	Lowest					Bweri HC and Suguti Disp

It is interesting to note that of all eight facilities, six fit the predicted pattern (see table 10.3). The six facilities conform to the proposition that high facility implementation fidelity results in high client responsiveness. That means that generally the level of facility implementation fidelity corresponds with the level of clients' responsiveness. Two facilities, Majengo and Pasua health centres, from Moshi MC, divert from the pattern: while they scored 'highest client responsiveness' they had merely 'high facility implementation fidelity'. Clients of these facilities were on average well informed and did not need much advice any more. This parallels the findings in the previous section that Moshi MC implementation fidelity does not fit the pattern of the relationship with CPR. As shown in the first section, the LGA's client responsiveness did fit the pattern with CPR.

10.3.3 Facility implementation fidelity and planning

It was assumed that the better the LGA planned its family planning activities, the higher the implementation fidelity in the facilities would be. So the purpose of this section is to ascertain whether the facility implementation fidelity is associated with LGA planning. Table 10.4 suggests that the facility implementation fidelity has little association with LGA planning. Out of eight facilities four facilities fit the pattern completely. The most deviating case is the Nyasho health facility. This means that a facility can have high implementation fidelity without an explicit written programme implementation plan at the facility and at the LGA level. The Majengo and Pasua health centres had high implementation fidelity while the corresponding LGAs had a moderate level of planning.

Table 10.4: Relationship between LGA planning and facility implementation fidelity

		LGA planning			
Implementation fidelity		High	Moderate	Low	Lowest
	Highest and High	Himo HC and Kiruwa HC	Majengo HC and Pasua HC		
	Moderate				Nyasho HC
	Low			Murangi HC	
	Lowest			Suguti Disp.	Bweri HC

Thus, differences in implementation fidelity cannot be attributed to differences in LGA planning. The question now is, how this deviation from the predicted pattern can be explained. Table 10.4 show that planning was relatively more developed in the rural districts than in the urban districts. As was discussed in chapter 8, most facilities in the municipal councils were providing services without any written plan or stated targets. They were just providing contraceptives, as if they were a shop. Clients from urban areas are well informed and capable of selecting a contraceptive method by themselves. In rural areas providers need to actively advocate family planning and the use of contraceptives. That could induce a more planning-oriented attitude in the facilities.

It is thought that another factor besides the quality of the LGA plans is far more important: that is the level of training of the health workers. It is logical to assume that the better trained the provider; the better the provider will adhere to the national standards and guidelines. After all, the training they receive is all about the application of those guidelines and protocols. As discussed in detail in chapter 7, all health workers working in family planning units at Majengo, Pasua, Himo and Kiruwa Vunjo health centres (from Moshi MC and Moshi DC) had been trained to provide long acting and short acting methods. Meanwhile, the health workers active in Nyasho, Bweri, and Murangi health centres (from Musoma MC and Musoma DC) were merely trained to provide short acting methods. The health worker providing family planning services in Sunguti dispensary had never attended any training on family planning and even lacked a formal nursing training.

This implies that the programme implementation mechanism is not intergovernmental, as was hypothesised in chapter 3. Rather it is professional and NGO-driven. Professionals are trained by other professionals, under the guidance and pressure of NGOs, with a token involvement of the ministry. Thus, the training is the key to implementation fidelity in the facilities rather than LGA planning.

10.3.4 Adaptation

After having established the general implementation fidelity now it is time to take a close look at some specifics of the implementation process. How do health workers react to specific circumstances during programme implementation? Do they deviate from the guidelines and national programmes? The facilities show some evidence of coping strategies or *adaptation* in the provision of family planning services. The *adaptation* might be positively fostering the programme or negatively hindering some of the delivery of programme components.

One provider from Himo health centre was encouraging her clients to use more long acting methods with the purpose of reducing the workload. The idea behind this *adaption* was that long acting methods require clients to return to the facility merely once every three or twelve years (if they do not experience any problems). Clients using short acting methods on the other hand need to return to the facility every three months to receive a new dose of the contraceptive. This affects the programme positively in such a way that public resources are efficiently utilised. Also the provider might have enough time to spend with clients since she had few clients or engaged into other activities. Yet it might have a negative influence concerning women's informed choice and therefore be a breach of implementation fidelity.

Another health worker (from Kiruwa Vunjo health centre) inspired her clients by providing information about what methods are commonly used by the health professionals themselves. She was encouraging clients to use an IUCD by assuring them that it is a non-hormonal method that does not have any side effects. This affects the programme positively in sense that it increases the number of contraceptive users by influencing the clients to use IUCD believing that the method used by the health professional is good method. However, it contradicts the guideline concerning the concept of informed choice that dictates that the provider must explain to the clients' the available methods, allowing clients to decide for her/himself the methods s/he will use. The two examples show that the health workers in Moshi DC tend to influence their clients to use long acting methods rather than short acting methods.

Providers from Nyasho and Bweri health centres from Musoma MC were encouraging their clients to use short acting methods. The motive to prevent the clients from using long acting methods was that it enabled the health workers to stick to what they could do. They did not have the capacity to provide long acting methods. This strategy affects the programme negatively since it restricts deliverance of some of the programme components.

Adaptation was not found among the providers alone. Some of the clients were using the contraceptives without the knowledge of their husbands. The contraceptive most used was injectable methods. Also, clients left their ID card in the facility where their spouses could not find them and discover that

they were using contraceptive. This practice was most common at Nyasho and Bweri health centres from Musoma MC.

Overall, deviations from the general guidelines found in the different facilities cannot be qualified as a breach of implementation fidelity: they are adaptations that keep the implementation of the programme going under adverse conditions. Nevertheless, there are some secondary effects that do run counter to the intentions of the national guidelines.

10.4 LGAs' implementation practices

The assumption is that a high level of LGA *adherence* will correspond with a high *quality* of services provided, and a low level adherence with a low quality. Furthermore, high quality service delivery should produce a high CPR. The LGA level of *adherence* with national guidelines can be reflected in the LGA plans. The purpose of this section is to determine whether the differences in quality of planning (adherence) correspond with the differences in CPR across the LGAs.

One interesting result is that there is no relation to be found between LGA planning and CPR. As shown in the table 10.5 none of the LGAs fits the predicted pattern. Half of them had a high level of planning (Moshi DC and Musoma DC) but a low level of CPR while another half had a low level of planning (Moshi MC and Musoma MC) but a high level of CPR.

Table 10.5: Relationship between LGA planning and CPR

		LGA planning			
		High	Moderate	Low	Lowest
CPR	High		Moshi MC		
	Moderate	Moshi DC			
	Low				Musoma MC
	Lowest			Musoma DC	

The documents produced by local authorities showed some level of *adherence* with those produced by the Ministry of Health and Social Services by including the family planning in their plans. Moshi DC, Musoma MC and Musoma DC included family planning activities in their plans/CCHP. As table 10.5 shows, Moshi DC and Musoma DC had a high level of planning but a lower level of CPR. The fact that Moshi MC did not write anything concerning family planning in its CCHP warrants the conclusion that the managers and the providers perform their tasks in family planning without any written plans. In addition, it was established that there was no written planning in all facilities studied. So, the manager and providers of those facilities provide family planning services without any written planning. This is discussed in detail in chapter 7 and 8.

10.4.1 Programme reach

There were differences found in programme reach across LGAs. This too corresponds with differences in CPR. Table 10.6 shows that half of the LGAs (Moshi MC and Moshi DC) fit the predicted pattern, (high programme reach corresponding with high CPR) while the other half (Musoma municipal and Musoma DC) does not fit the pattern. This deviation from the pattern can be explained taking into account an increase in programme reach in those two LGAs that was discussed in detail in chapter 8.

Table 10.6: Relationship between programme reach and CPR

		Programme reach			
		Highest	High	Low	Lowest
CPR	Highest	Moshi MC			
	High		Moshi DC		
	Low		Musoma MC		
	Lowest		Musoma DC		

Table 10.6 shows an unpredicted high programme reach in Musoma MC and Musoma DC. That fact can be explained by the intensification of efforts done in the Mara region as discussed clearly in chapter 8. The effort was directed at the Lake Zone after government officials (from the Ministry of Health and Social Services) established that Mara region had the lowest CPR of all regions. These efforts have increased the programme reach to the levels observed. The CPR is naturally lagging behind, since that was at a very low level until recently. In addition, referring to earlier remarks in previous sections, even though Mara´s councils show a high programme reach, their implementation outcomes are not very good. This again was attributed to the low quality of service delivery. Intensification of effort without the allocation of well trained staff is bound to fail.

One indication of the limited *programme reach* in the Mara region LGA´s is the availability of the cue card and procedure manual, as discussed in detail in chapter 8. Observations showed that all facilities in Moshi MC and Moshi DC displayed the cue card on their table while at Musoma MC only one facility displayed the cue card and at Musoma DC no facility displayed the cue card in their table. In addition, only one facility from Moshi MC and one from Moshi DC had the Family Planning Procedure Manual (2012) document. Again, this goes back to the level of training. Well trained health workers have learned to use the cue card, and have been trained in applying the manual as well. As pointed out before, the providers from Moshi MC and Moshi DC were far more trained than their counterparts from Musoma MC and Musoma DC.

10.4.2 Allocation of health workers at family planning units

The national programme coordinator was aware of the numbers of health workers trained in family planning in each of the LGAs. Table 10.7 shows those data for the four LGA cases in this research. Yet the managers of those LGAs had no idea about how many health workers in their jurisdiction had been trained in family planning. The ministry itself in cooperation with NGOs generates the available data at the national level through the MoHSW training track system. This is an online system that requires every trainer to record the training conducted online.

Table 10.7: Number of health workers at LGAs trained on family planning from 2010 to 2015

LGA	Health worker trained on short term methods	Health worker trained on long term methods	Total
Moshi MC	42	10	52
Moshi DC	63	35	98
Musoma MC	25	20	45
Musoma DC	42	10	52

Table 10.8: Number of health workers at health facilities trained on short-term and long-term methods from 2010 to 2015

Health facilities	Health worker trained on short term methods	Health worker trained on long term methods	Total
Majengo HC	8	2	10
Pasua HC	9	1	10
Kirua Vunjo HC	6	2	8
Himo OPD HC	5	2	7
Nyasho HC	8	3	11
Bweri HC	5	4	9
Murangi HC	4	4	8
Suguti DISP	0	0	0

It is surprising that all eight facilities except Suguti had health workers trained to provide both short acting and long acting methods. Yet, the providers allocated at the family planning units in Nyasho, Bweri and Murangi health centres from Musoma MC and Musoma DC were trained to provide short term methods only: table 10.9. Table 10.8 shows that Murangi, Bweri and Nyasho health centres had relative high numbers of health workers that had been trained in the provision of long term methods; still they were not allocated to a family planning unit.

Table 10.9: Training attended by health workers active in family planning units in 2014

Health facilities	Precence of health worker trained on short term methods	Precence of health worker trained on long term methods
Majengo HC	V	V
Pasua HC	V	V
Kirua Vunjo HC	V	V
Himo OPD HC	V	V
Nyasho HC	V	0
Bweri HC	V	0
Murangi HC	V	0
Suguti DISP	0	0

There are some possible explanations for this state of affairs as depicted in previous tables. It is possible that health workers were trained while working in a family planning unit and have since been re-assigned. It is also possible that health workers were allowed to attend a training without the intention to have them assigned to a family planning unit. Training is sometimes considered a personal perquisite rather than a resource for the health facility. Most of these health workers are trained as nurse midwives with an additional training on how to provide family planning services. Another explanation might be that those who attended the training were facilities managers i.e. matrons or heads of department, staff that is not actively involved in the provision of family planning services.

While the facilities in Moshi MC and Moshi DC made proper use of the available staff, Musoma MC and Musoma DC did not use their capacity to full potential. Musoma MC and Musoma DC were misusing their health workers by allocating the trained health workers to other units than family planning. It can be considered an improper use of public funds that affected the programme negatively by reducing the *quality* of services offered.

Although I consider this as improper use of trained staff, it was described in chapter 7 that there was staffing pressure in these LGAs in Mara: they were forced to divert scarce resources to other units of the facility. However, what is more important is the fact that this study established that the staff who are actually doing the worked are not well trained in the Mara LGAs when compared with the staff in the Kilimanjaro LGAs. This factor is the key to deficiencies in implementation fidelity and goes a long way in clarifying the differences in CPR.

All LGAs conducted supervision *(monitoring)* every month. The conducted supervision was mainly mentoring and supportive supervision. There were no noticeable supervision differences across the local authorities' cases. However, one LGA (Musoma DC) took some control measures to feed the infor-

mation generated during supervision back to the facilities that had challenges observed during supervision. It involves discussion with health workers on possible contributing factors and ways to address shortcomings. This LGA was performing both monitoring and control simply because it already identified as the LGA with lowest CPR in the country as discussed in detail in chapter 7. Therefore, there was no evidence that suggests a relationship between monitoring and control with CPR.

10.5 Implementation fidelity between the central government and the LGA

The section is intended to explore if the central implementation fidelity explains the differences in LGAs' CPR. The findings suggest that the Ministry of Health and Social Services regulated all training conducted by different NGOs and Zonal Health Resource Centres (ZHRC) and made sure that they were using the guidelines that were prepared by the ministry. This provides evidence that the training conducted *adhered* with the programme training manuals produced by the ministry.

The results of the present study also suggest that the ministry of health did not produce sufficient numbers of programme documents to be distributed to all implementers in the LGAs. Some of the programme managers and providers did not have the programme documents and this in turn affected *programme reach* and eventually affected the *implementation fidelity.* It is hypothesised that having the programme documents increases the likelihood to *adhere* with programme objectives, activities and provide *quality* services that was evident in the LGAs that had the programme documents.

Moreover, the central government conducted very few supervisions compared with what was recommended by the guidelines. Also, the regional reproductive and child health sections in both regions lacked the programme plans or targets that would have guided the monitoring and evaluation after a specified period of time.

The conclusion is that there is no evidence that the activities of the central government contributed to the CPR differences across LGA – simply because the implementation fidelity at central level was low and was almost the same across all regions and LGAs studied.

10.6 Influence of other organisations that provide family planning services

Do differences in CPR correspond with the presence or absence of NGOs, Zonal Health Resource Centres (ZHRC) and dominant religion organisation(s) at the LGAs? This is the question that is to be answered in this section. Only one NGO, EngenderHealth, was actively participating in the im-

plementation of the family planning programme. Moreover, out of eight ZHRCs only the Centre for Educational Development in Health (CEDHA), was actively executing the family planning programme. The other ZHRCs were dormant.

As revealed in previous chapters, there was a significant difference between LGAs and facilities in the number of health workers trained. Also, dissimilarity was observed concerning the organisations that conducted the training. The bulk of the training at Moshi MC was done by MoHSW, Moshi district, EngenderHealth, Musoma DC MoHSW, and Musoma MC MoHSW, EngenderHealth and CEDHA. Still, Musoma MC had fewer providers who were trained than the other LGAs.

Differences in organisations that conducted training impacted the differences in the *exposure* across LGA's. For instance, the main trainer at Moshi DC was EngenderHealth. As a result, Moshi DC had more health workers who were trained to provide long acting methods than other LGA-cases. The data provide evidence that vicinity to EngenderHealth and CEDHA has impacted the quality of the family planning providers of Moshi MC and Moshi DC positively. These two LGAs received more support from the ZHRC and NGOs than Musoma MC and Musoma DC.

Parenthetically, it seems that religion had little bearing on the programme reach. The Roman Catholic organisation for instance had a strict ban on the use of contraceptives. Nevertheless, according to council managers and providers, many Catholic clients were unrestricted in the use of family planning services. But they acquired the services from health facilities that was not owned by the Roman Catholic organisation.

The differences in ZHRCs and NGOs working in LGA, could explain to some extent the observed CPR difference. The religion organisations did not show any evidence to influence the CPR.

10.7 Concluding remarks

10.7.1 General

The central research question of this study was, to which extent differences in implementation practices can explain differences in CPR.

The government's aim in repositioning the family planning programme in 2010 was to accelerate the growth of CPR as a way to combat maternal and child mortality. The programme was designed in such a way that it was to be implemented in an equal way all over the country. All regions and LGAs were expected to have the same level of *implementation fidelity*, *monitoring of control* and *programme reach*. Differences were expected in *adaptation* and *client responsiveness* because these properties are outside the control of the programme.

The findings of this study show that there were indeed differences in implementation practices between Mara region with low level CPR and Kilimanjaro region with high CPR. More specifically, there were differences in programme fidelity and programme reach. These differences in turn can, to a large degree, be attributed to differences in knowledge and skills of health workers working in family planning units. There were also differences in LGA planning, differences in NGOs and differences regarding ZHRCs working in regions and LGAs but they turned out to be of little importance in explaining programme fidelity and programme reach.

More generally, this study found that the family planning programme implementation was not intergovernmental, as hypothesised in chapter 3. Rather it was inter-professional. The NGO's make professional short cuts by directly training local staff in the guidelines and protocols, circumventing local planning activities. Even though the staff in the Mara LGA's did not make sure that the best trained staff was actually allocated to the family planning units doing the programme implementation, this training shortcut only works if the people who are trained are actually assigned as family planning providers. So the general answer to the question why there is such a difference in CPR is: because the Mara region LGAs do not employ properly trained providers. These findings suggest that in general the training (in implementing the guidelines), the role of the NGO's and personnel are three components that contribute largely in explaining differences in implementation fidelity in facilities and thus in CPR.

10.7.2 Programme inference and recommendations

Future programme design can consider having difference implementation strategy across regions and LGAs. Rather than having one strategy that is implemented equally all over the country whiles each region and LGA had the different level of CPR. Having a separate implementation strategy is more likely to strengthen the programme implementation. High effort should be done in the area where there low socioeconomic status. These efforts should stress on high quality advices done with skilled health worker that had been trained in provision of both long and short acting contraceptives. Targeting the areas which have low level of CPR which is mainly in the rural areas.

10.7.3 Inference for the ministry, LGAs and recommendations

Apart from the mother document (NFPCIP) the ministry prepares other documents that foster the implementation of the family planning programme in Tanzania. The findings of this study show that the ministry did not produce enough copies to be distributed to all implementers. For the future programme the ministry should consider increasing the budget for the production, dissemination and distribution of the programme documents to the cor-

responding organisations that implement the programme activity intended by the document.

Increasing the quality of programme implementation requires increasing the quality of staff. In addition, if you do have staff trained, you should use it properly and allocate those people for the job for which they were trained. The findings make clear that there were staff members trained in family planning who were not working in a family planning unit. The immediate action that should be taken is to allocate trained health workers to work in family planning units. The ministry could effectuate this through communicating with LGAs managers, informing them about the health workers who received training in family planning. These data are readily available at the ministry. In addition, the manager should be trained on the handling and application of human resources management data so as to improve the quality of the health center's activities.

The study findings showed that the LGAs planning differ in areas such as intervention, identification of the problem associated with family planning and strategies to address the problem. Training attended by the providers who were providing the family planning services and the *quality* of services delivered was another area that differs. None of the LGAs has specified in writing any family planning implementation targets. The LGAs could increase the *quality* of family planning services provision through training health workers as providers of family planning services and stationing them permanent in family planning units. Training the providers on how to create programme plans and targets at facility level is a necessity, too. The CHMT team and CHPT team needs to be urged to integrate family planning programming into local authority plans. This might be done by local authorities through identifying the existing family planning problem; setting the objectives and targets, together with the activities that will be done to realise the stated targets.

10.7.4 This study and the literature

This study provides a number of findings that enhances our understanding of programme implementation. The findings show that the CPR is a function of quality of implementation, and quality of implementation is a function of quality of training of providers. Training turned out to be of overriding importance, even in this intergovernmental process of programme implementation. It would seem that the literature on intergovernmental implementation more or less ignores such factors. The literature on the implementation of medical programmes on the other hand ignores the intergovernmental component. It is largely limited to analysing the effects of a single implementation property (Durlak and DuPre 2008). This study combined insights of programme and intergovernmental implementation by incorporating seven properties of programme implementation into one study, analysing an intergovernmental implementation process.

Bibliography

ABDEL-TAWAB N, ROTER D. (2002), The relevance of client-centered communication to family planning settings in developing countries: lessons from the Egyptian experience. *Social Science Medical*, 54(9): 1357-1368.

AGWANDA, ALFRED, ANNE KHASAKHALA, AND MAUREEN KIMANI. (2009), *Assessment of Family Planning Services in Kenya: Evidence from the 2004 Kenya Service Provision Assessment Survey*. Kenya Working Papers No.4. Calverton, Maryland, USA: Macro International Inc.

ALDANA JM, PIECHULEK H, AL-SABIR A. (2001), Client satisfaction and quality of health care in rural Bangladesh. *Bulletin of the World Health Organisation* 79(6).

ALKEMA, L., et al. (2013), National, regional, and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015: a systematic and comprehensive analysis. *Lancet* 381(9878): 1642-5

ALMAZ TEREFE AND CHARLES P. LARSON, (1993), Modern Contraception Use in Ethiopia: Does Involving Husbands Make a Difference? *American Journal of Public Health,* 83(11): 1567-1576.

ANDRIES HOOGERWERF (1990), Reconstructing policy theory. *Evaluation and programme Planning,* 13: 285-291.

ANNA T. K and NASSORO R. (2006), Utilisation of modern family planning methods among women of reproductive age in rural setting: the case study of Shinyanga rural district, Tanzania, East Africa *Journal of Public Health* 3(2): 26-30.

ARGAGO, T. G., HAJITO, K. W., and KITILA, S. B. (2015), Clients satisfaction with family planning services and associated factors among family planning users in Hossana Town Public Health Facilities, South Ethiopia: Facility-based cross-sectional study. *International Journal of Nursing and Midwifery*, *7*(5): 74-83.

ASSEFA F, MOSSE A, MICHAEL Y (2011), Assessment of Clients' Satisfaction with Health Service Deliveries at Jimma University Specialised Hospital. *Ethiopia Journal of Health Science* 21(2): 101–109.

AUGUST, G. J., EGAN, E. A., REALMUTO, G. M., and HEKTNER, J. M. (2003A), Parceling component effects of a multifaceted prevention pro-

gramme for disruptive elementary school children. *Journal of Abnormal Child Psychology,* 31: 515–527.

AUGUST, G. J., LEE, S. S., BLOOMQUIST, M. L., REALMUTO, G. M., and HEKTNER, J. M. (2003B), Dissemination of an evidence-based preventive intervention for aggressive children living in diverse, urban neighbourhoods. *Prevention Science,* 4: 271–286.

AYOUB S. A, (2004), Effects of women's schooling on contraceptive use and fertility in Tanzania. *African population studies,* 19(2*)* 140-157.

BARRETT, D. AND A.O. TSUI, (1999), 'Policy as symbolic statement: international response to national population policies', *Social Forces*, 78(1): 213–234.

BAYDAR, N., REID, M. J., and WEBSTER-STRATTON, C. (2003), The role of mental health factors and programme engagement in the effectiveness of a preventive parenting programme for Head Start mothers. *Child Development,* 74:1433–1453.

BELL, M. L., KELLEY-BAKER, T., RIDER, R., and RINGWALT, C. (2005), Protecting You/Protecting me: Effects of an alcohol prevention and vehicle safety programme on elementary students. *Journal of School Health,* 75: 171–177.

BENNETT, S., GHAFFAR, A., MILLS., YESUDIAN, M., and MENDELBAUM-SHMIDT, J. (2007), What is Health Policy and Systems Research and why does it matter? *Briefing note,* (1): 1-8.

BERKEL, C., MAURICIO, A. M., SCHOENFELDER, E., and SANDLER, I. N. (2011), Putting the pieces together: An integrated model of programme implementation. *Prevention Science*, *12*(1): 23-33.

BIRKLAND, T. A. (2014), *An introduction to the policy process: Theories, concepts and models of public policy making*. Routledge.

BLAKE, S. M., SIMKIN, L., LEDSKY, R., PERKINS, C., and CALABRESE, J. M. (2001), Effects of a parent-child communications intervention on young adolescents' risk for early onset of sexual intercourse. *Family Planning Perspectives*, 33: 52–61.

BLANC, A. K., CURTIS, S. L., and CROFT, T. N. (2002), Monitoring contraceptive continuation: links to fertility outcomes and quality of care. *Studies in family planning*, *33*(2):127-140.

BUSE K., MAYS N. and WALT G. (2005), Making Health policy, Ashford Colour Press ltd, Gosport Hampshire Uk.

CARROLL, C., PATTERSON, M., WOOD, S., BOOTH, A., RICK, J., and BALAIN, S. (2007), A conceptual framework for implementation fidelity. *Implementation Science,* 2: 40-49.

CENTURY et al., (2010), A framework for measuring fidelity of implementation: A foundation for shared language and accumulation of knowledge. *American Journal of Evaluation,* 31 (2): 199–218

CHEUNG, K. K., MIRZAEI, M., and LEEDER, S. (2010), Health policy analysis: A tool to evaluate in policy documents the alignment between policy statements and intended outcomes. *Australian Health Review, 34*(4): 405-413.

CHITAMA, D., BALTUSSEN, R., KETTING, E., KAMAZIMA, S., NSWILLA, A., and MUJINJA, P. G. (2011), From papers to practices: district level priority setting processes and criteria for family planning, maternal, newborn and child health interventions in Tanzania. *BMC women's health*, *11*(1): 46.

COLEBATCH, H. (2006), What Work Makes Policy? *Policy Sciences*, 39(4): 309-321.

DANE, A. V., and SCHNEIDER, B. H. (1998), Programme integrity in primary and early secondary prevention: Are implementation effects out of control. *Clinical Psychology Review,* 18: 23–45.

DARROCH J.E. (2008), Male fertility control — where are the men? *Contraception,* 78: S7–S17.

DOMITROVICH, C. E., and GREENBERG, M. T. (2000), The study of implementation: Current findings from effective programmes that prevent mental disorders in school-aged children. *Journal of Educational and Psychological Consultation,* 11: 193–221.

DURLAK, J. A. (1997), *Successful prevention programmes for children and adolescents*. New York: Plenum

DURLAK, J. A., and DUPRE, E. P. (2008), Implementation matters: A review of research on the influence of implementation on programme outcomes and the factors affecting implementation. *American Journal of Community Psychology,* 41: 327–350.

DUSENBURY, L., BRANNIGAN, R., FALCO, F., and HANSEN, W. B. (2003A), A review of research on fidelity of implementation: implications for drug abuse prevention in school settings. *Health Education Research,* 18: 237–256.

DUSENBURY, L., BRANNIGAN, R., FALCO, M., and LAKE, A. (2003B), An exploration of fidelity of implementation in drug abuse prevention among five professional groups. *Journal of Alcohol and Drug Education*, 47: 4–19.

EAGER, P.W. (2004), *Global Population Policy: From Population Control to Reproductive Rights.* Burlington: Ashgate.

ELLIOTT, D. S., and MIHALIC, S. (2004), Issues in disseminating and replicating effective prevention programmes. Prevention Science, 5: 47–52.

FAGAN, A.A., HANSON, K., HAWKINS, J.D., and ARTHUR, M.W. (2008), Bridging science to practice: Achieving prevention programme implementation fidelity in the community youth development study. *American Journal of Community Psychology, 41*: 235-249.

FLICK, U. (2009), *An introduction to qualitative research*. Sage.

FORGATCH, M. S., PATTERSON, G. R., and DEGARMO, D. S. (2005), Evaluating fidelity: Predictive validity for a measure of component adherence to the Oregon model of parent management training. *Behavior Therapy,* 36: 3–13.

GARVEY, C., JULION, W., FOGG, L., KRATOVIL, A., and GROSS, D. (2006), Measuring participation in a prevention trial with parents of young children. *Research in Nursing and Health,* 29: 212–222.

GILSON, L., and RAPHAELY, N. (2008), The terrain of health policy analysis in low and middle income countries: A review of published literature 1994-2007. *Health Policy and Planning, 23*(5): 294-307.

GRIZZLE, M. (2012), *Family Planning | White Paper World Youth Alliance,* New York.

HALL, W. J., ZEVELOFF, A., STECKLER, A., SCHNEIDER, M., THOMPSON, D., PHAM, T., GROUP, H. S. (2012) Process evaluation results from the HEALTHY physical education intervention. *Health Education Research,* 27(2): 307-318.

HANSEN, W. B. AND GRAHAM, J. W. (1991), Preventing alcohol, marijuana, and cigarette use among adolescents: Peer pressure resistance training versus establishing conservative norms. *Preventive Medicine*, 20: 414–430.

HILL, L. G., MAUCIONE, K., and HOOD, B. K. (2007), A focused approach to assessing programme fidelity. Preventive Science, 8(1): 25-34.

HILL, M. and HUPE, P. (2009). *Implementing Public Policy*. 2nd Edition, Los Angeles, CA: Sage.

HJERN, B., and PORTER, D. O. (1979). *Implementation Structure: A New Unit of Administrative Analysis*. Internat. Inst. of Management, Wissenschaftszentrum Berlin.

HOPPER, C. A., MUNOZ, K. D., GRUBER, M. B., MACCONNIE, S., SCHONFELDT, B., and SHUNK, T. (1996), A school-based cardiovascular exercise and nutrition programme with parent participation: An evaluation study. *Children's Health Care, 25*: 221–235.

HUTCHINSON *et al.* (2011), Measuring client satisfaction and the quality of family planning services: A comparative analysis of public and private health facilities in Tanzania, Kenya and Ghana. *BMC Health Services Research, 11(203)* 11(1): 1-17

LALONGO, N., WERTHAMER, L., KELLAM, S. G., BROWN, C. H., WANG, S., and LIN, Y. (1999), Proximal impact of two first-grade preventive interventions on the early risk behaviors for later substance abuse, depression, and antisocial behavior. *American Journal of Community Psychology, 27*: 599–641.

JUDICE, N., E. SNYDER. 2013, *Measuring Progress on Repositioning Family Planning in Tanzania.* Washington, DC: Futures Group, Health Policy Initiative, Task Order 5.

KAM, C.M., GREENBERG, M. T., and WALLS, C. T. (2003), Examining the role of implementation quality in school-based prevention using the PATHS curriculum. *Prevention Science, 4*: 55–63.

KEELE, J. J., FORSTE, R., and FLAKE, D. F. (2005), Hearing native voices: Contraceptive use in Matemwe village, east Africa. *African Journal of Reproductive Health, 9*(1): 32-41.

KOMRO, K. A., PERRY, C. L., VEBLEN-MORTENSON, S., FARBAKHSH, K., KUGLER, K. C., ALFANO, K. A., et al. (2006), Cross-cultural adaptation and evaluation of a home-based programme for

alcohol use prevention among urban youth: The ‘‘Slick Tracy Home Team Programme’’. *The Journal of Primary Prevention*, 27: 135–154

L'ENGLE, K. L., VAHDAT, H. L., NDAKIDEMI, E., et al. . (2013), Evaluating feasibility, reach and potential impact of a text message family planning information service in Tanzania. *Contraception,* 87: 251–256.

LANTIS K, GREEN C, JOYCE S. (2002), *Providers and quality of care*. In: Mickle H, ed. New perspectives on quality of care, No. 3. Population Reference Bureau

LEE, K., LUSH L., WALT, G., AND CLELAND, J., (1998), *family planning policies and programmes in eight low-income countries: A comparative policy analysis*, London School of Hygiene and Tropical Medicine, Health Policy Unit, Keppel Street, London WCIE 7HT, UK.

LIAMPUTTON P. and EZZY, D. ED (2005), *Qualitative Research Methods*, Oxford University Press.

LIPSKY, MICHAEL (1971), 'Street Level Bureaucracy and the Analysis of Urban Reform,' *Urban Affairs Quarterly 6*: 391-409.

MATLAND, R. E. (1995), Synthesizing the Implementation Literature: The Ambiguity-Conflict Model of Policy Implementation. *Journal of Public Administration Research and Theory*: 145-174.

May, J. (2012). *World Population Policies: Their Origin, Evolution, and Impact*, New York: Springer.

MCGRAW, S.A., SELLERS, D.E., STONE, E. J., BEBCHUK, J., EDMUNDSON, E.W., JOHNSON, C. C., et al. (1996), Using process data to explain outcomes: An illustration from the Child and Adolescent Trial for Cardiovascular Health (CATCH). *Evaluation Review,* 20: 291–312.

MIRO, C. and POTTER, J. (1980), *Population Policy. Research Priorities in the Developing World,* London: Francis Pinter.

MKINI, F. A. H. I980, 'Current population policy in the United Republic of Tanzania', in Economic Commission for Africa/International Labour Organisation, ed., *Final Report on the National Seminar on Population and Development in the United Republic of Tanzania*. Arusha: UNFPA, 62-73.

MOHAMED M. ALI, JOHN CLELAND, (2010), Oral contraceptive discontinuation and its aftermath in 19 developing countries. *Contraception,* 81(1): 22–29.

MOLLEL, H. (2010), *Participation for local development. The reality of decentralization in Tanzania*. Leiden: African studies centre.

MOSADEGHRAD AM (2014), Factors influencing healthcare service quality. *International Journal of Health Policy and Management.* 3(2): 77–89.

MOWBRAY, C. T., HOLTER, M. C., TEAGUE, G. B., and BYBEE, D. (2003), Fidelity criteria: Developmental, measurement, and validation. *American Journal of Evaluation,* 24: 315–340.

MSOFE, GRACE E.P KIONDO, ELIZABETH. (2009), Accessibility and use of family planning information (FPI) by rural people in Kilombero

District. *Africa Journal of Library, Achives and Information Science* 19(2): 117-127.
MUELLER, R. (1993), Human Rights, Women's Rights, and Reproductive Freedom: The Evolution of Ideas, In R. Dixon-Mueller (Ed.), *Population Policy and Women's Rights: Transforming Reproductive Choice*. Westport: Praeger Publishers.
Musau, Stephen, Grace Chee, Rebecca Patsika, Emmanuel Malangalila, Dereck Chitama, Eric Van Praag and Greta Schettler. (2011), *Tanzania Health System Assessment 2010.* Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.
NATIONAL BUREAU OF STATISTICS (NBS) [TANZANIA] AND MACRO INTERNATIONAL INC. (2007). *Tanzania Service Provision Assessment Survey 2006.* Dar es Salaam, Tanzania: National Bureau of Statistics and Macro International Inc.
NATIONAL BUREAU OF STATISTICS (NBS) AND ORC MACRO (2011), *Tanzania Demographic and Health Survey 2010*, Dar es Salaam Tanzania: National Bureau of Statistics and ORC Macro.
NATIONAL BUREAU OF STATISTICS (NBS) AND OFFICE OF CHIEF GOVERNMENT STATISTICS (OCGS) ZANZIBAR (2013), *Population and Housing Census:* Dar es Salaam, Tanzania: NBS and OCGS.
NYE, C. L., ZUCKER, R. A., and FITZGERALD, H. E. (1995), Early intervention in the path to alcohol problems through conduct problems: Treatment involvement and child behavior change. *Journal of Consulting and Clinical Psychology,* 63: 831–840.
OLAITAN O. L. (2011), Factors influencing the choice of family planning among couples in Southwest Nigeria. *International Journal of Medicine and Medical Sciences* 3(7): 227-232
PATTON, M.Q. (2002), *Qualitative Research and Evaluation Methods.* Thousand Oaks, CA: Sage.
SABATIER P. A., (1986), Top-Down and Bottom-Up Approaches to Implementation Research: a Critical Analysis and Suggested Synthesis. *Journal of Public Policy, 6*: 21-48.
PILE, J. M., AND SIMBAKALIA, C. 2006, *Repositioning family planning—Tanzania case study: A successful programme loses momentum.* New York: EngenderHealth/The ACQUIRE Project.
PRADO, G., PANTIN, H., SCHWARTZ, S. J., LUPEI, N. S., and SZAPOCZNIK, J. (2006), Predictors of engagement and retention into a parent centred, ecodevelopmental HIV preventive intervention for Hispanic adolescents and their families. *Journal of Paediatric Psychology,* 31: 874–890.
PRITCHETT, L., WOOLCOCK, M., AND ANDREWS, M. 2010, Capability Traps? The Mechanisms of Persistent Implementation Failure, *Working Paper 234*, Washington, DC: Center for Global Development.
RESNICOW, K., DAVIS, M., SMITH, M., LAZARUS-YAROCH, A., BARANOWSKI, T., BARANOWSKI, J., et al. (1998), How best to

measure implementation of school health curricula: A comparison of three measures. *Health Education Research,* 13: 239–250.

RICHEY, L. (1999), Family planning and the politics of population in Tanzania: International to local discourse. *Journal of Modern African Studies, 37*(3): 457-487.

RICHEY, L. A. (2002), Is over-population still the problem? global discourse and reproductive health challenges in the time of HIV/AIDS. *CDR Working Paper, 2*(1): 1-21.

RICHEY, L. A. (2004), Construction, control and family planning in Tanzania: some bodies the same and some bodies different. *Feminist Review,* 78: 56–79.

RICHEY, L. A. (2008), Global knowledge/local bodies: Family planning service providers' interpretations of contraceptive knowledge(s). *Demographic Research, 18*: 469-498.

RICHEY, L. A. (2008), Population politics and development: From the policies to the clinic, Palgrave Macmillan, New York.

RICHEY, L. A. (2009), *Population politics and development: From the policies to the clinics*. Kampala-Uganda: Fountain Publishers.

RINGERS, P.A (1999), Contraceptive decision-making: *the Wachagga of Kilimanjaro, Tanzania*. (Unpublished) http://www.popline.org/node/524610 [Accessed on 14 December 2014].

ROSS KINEMO (1995), Abortion and family planning in Tanzania. *Journal of Management Development* 7(2)

RÜTTEN, A., LÜSCHEN, G., LENGERKE, T. V., ABEL, T., KANNAS, L., DIAZ, J., et al. (2003), Determinants of health policy impact: A theoretical framework for policy analysis. *Sozial- Und Präventivmedizin,* 293.

SABATIER, P AND MAZMANIAN, D. (1979), 'The conditions of effective implementer: a guide to accomplishing policy objectives'. *Policy Analysis* 5(4): 481-504.

SAETREN, H. (2005), Facts and myths about research on public policy implementation: out of fashion, allegedly dead, but still very much alive and present, *Policy Studies Journal,* 33(4): 559-582.

SAUNDERS, R. P., WARD, D., FELTON, G. M., DOWDA, M., and PATE, R. R. (2006), Examining the link between programme implementation and behavior outcomes in the lifestyle education for activity programme (LEAP). *Evaluation and Programme Planning*, 29: 352–364.

SCHANKE, L. AND LANGE, S. (EDS) (2008), *'Decentralisation and Gender: Coordination and Cooperation on Maternal Health Issues in Selected District Councils in Tanzania'*, Christian Michelsen Institute, Bergen.

SCHOFIELD, J. (2001), Time for a revival? Public policy implementation: a review of the literature and an agenda for future research. *International journal of management reviews*, *3*(3): 245-263.

SLOBODA, Z., STEPHENS, P., PYAKURYAL, A., TEASDALE, B., STEPHENS, R. C., HAWTHORNE, R. D., WILLIAMS, J. E. (2009), Implementation fidelity: the experience of the Adolescent Substance Abuse Prevention Study. *Health Education Research,* 24(3): 394-406.

SMITH, T. B. (1973), The Policy Implementation Process. *Policy Sciences,* S. 197-209.

SPOTH, R., GUYLL, M., TRUDEAU, L., and GOLDBERG-LILLEHOJ, C. (2002), Two studies of proximal outcomes and implementation quality of universal preventive interventions in a community-university collaboration context. *Journal of Community Psychology,* 30: 499–518.

SUSAN C. and DAVID K. G. (2003), Determinants of Contraceptive Method Choice in Rural Tanzania between 1991 and 1999. *Studies in Family Planning,* 34(4): 263-276.

THOMAS, J.W. and GRINDLE, M.S. (1990), After the decision: Implementing policy reforms in developing countries, *World Development,* 18(8): 1163-1181.

TOLAN, P. H., HANISH, L. D., MCKAY, M. M., and DICKEY, M. H. (2002), Evaluating process in child and family interventions: Aggression prevention as an example. *Journal of Family Psychology,* 16: 220–236.

UNITE REPUBLIC OF TANZANIA MINISTRY OF HEALTH AND SOCIAL WELFARE (1989), *The National Family Planning Programme Plan of operation 1989-1993*. Dar es Salaam: MOH.

UNITED NATIONS DEVELOPMENT GROUP (2003), *Indicators for Monitoring the Millennium Development Goals: Definitions, Rationale, Concepts,* and Sources United Nations.

UNITED NATIONS POPULATION FUND (UNFPA) (2000), *United Nations Population Fund in Tanzania, 'Commemorating 25 years of Dedication to Population Assistance*: Dar es Salaam.

UNITED NATIONS, DEPARTMENT OF ECONOMIC AND SOCIAL AFFAIRS, POPULATION DIVISION (2013), *World Mortality Report 2013* (United Nations publication).

UNITED NATIONS, DEPARTMENT OF ECONOMIC AND SOCIAL AFFAIRS, POPULATION DIVISION (2014), *World Fertility Report 2013: Fertility at the Extremes* (United Nations publication).

UNITED NATIONS. (1987), Incentives, Disincentives and Family Planning. In United Nations Economic and Social Commission for Asia and the Pacific (Ed.), *Population Policies and Programmes: Current*

UNITED REPUBLIC OF TANZANIA (1990), *Economic Recovery Programme II 1989/90-1991/92: Report prepare by the government of Tanzania for the Meeting of the consultative Group for Tanzania Paris, December 1989.* Dar es Salaam.

UNITED REPUBLIC OF TANZANIA (1994), *Country Report on Population and Development, International Conference on Population and Development, in Cairo, Egypt, 5th–13th September*: Dar es Salaam.

UNITED REPUBLIC OF TANZANIA (URT), MINISTRY OF HEALTH AND SOCIAL WELFARE, (2010), *National Family Planning Costed Implementation Programme 2010-2015*, Dar es Salaam Tanzania: Ministry of Health and Social Welfare. Internet,

UNITED REPUBLIC OF TANZANIA (URT), MINISTRY OF HEALTH AND SOCIAL WELFARE, (2007), *National Health policy*, Dar es Salaam Tanzania: Ministry of Health and Social Welfare.

UNITED REPUBLIC OF TANZANIA, MINISTRY OF HEALTH AND SOCIAL WELFARE, (1990), *Health policy*, Dar es Salaam Tanzania: Ministry of Health and Social Welfare.

USAID. (I994), *Midterm Review of the Tanzania Family Planning Services Support (F.P.S.S.) Project.* Arlington, VA: Population and Technical Assistance Project.

USAID/HEALTH POLICY INITIATIVE, TASK ORDER 1, AND THE USAID | DELIVER PROJECT, TASK ORDER 1. (2010), *Assessing Policies and Practices That Affect Contraceptive Financing and Procurement: A Review*

VAN METER, DONALD AND VON HORN, CARL (1975), 'The Policy Implementation Process: A conceptual Framework'. *Administration and Society* 6: 445-88.

WALT, G. and GILSON, L. (1994), Reforming the health sector in developing countries: the central role of policy analysis, *Health Policy and Planning,* 9(4): 353-370.

WALT, G., SHIFFMAN, J., SCHNEIDER, H., MURRAY, S. F., BRUGHA, R., and GILSON, L. (2008), 'Doing' health policy analysis: Methodological and conceptual reflections and challenges. *Health Policy and Planning, 23*(5): 308-317.

WEINBERGER et al. (2013), Estimating the contribution of a service delivery organisation to the national modern contraceptive prevalence rate: Marie Stopes International's Impact 2 model. *BMC Public Health, 13(Supplement 2): S5.*

WHO (1994), *Population and Development, 'international Conference on population and Development in Cairo Egypt.* World Health Organisation: Geneva.

WORLD BANK (1989), *Report to the Consultative Group for Tanzania on the Government's Economic and Social Policy Reform Programme*, The World Bank Southern Africa Department.

WORLD BANK. (1988), *Meeting of Consultative Group for Tanzania: Current Economic Developments and Future Prospects*. Paris: World Bank.

World Health Organisation (2014), *Trends in maternal mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA.* The World Bank and the United Nations Population Division.

YIN R. K., ED., (2003), *Case Study Research Design and Methods*. London: Sage Publications, Inc.

Summary

Introduction

In 2012, Tanzania was recorded to have a total population of 44,928,923, which presents a four times increase when compared to the 1967 population of 12,313,469. It is believed that the high growth rate of the population in the country is caused by a persistent high fertility rate and declining mortality levels. Currently the country has a high fertility rate of 5.4, a number that stayed unchanged for two decades. This is considerably higher than the world average of 2.4. Although there is a decrease in mortality rates, which are still high in Tanzania compared to the world average. While Tanzania has an infant mortality rate of 81 per 1,000 live births, the world average is 37. The improvement is observed in under-five mortality where the country has a relative low rate of 51 deaths per 1,000 live births against the world average of 52 deaths per 1,000 live births. The most substantial differences are observed in the maternal mortality rate where Tanzania has 454 deaths per 100,000 live births compared to a world average of 210 deaths per 100,000 live births. Moreover, the differences are observed in dependency ratio across regions in Tanzania. Some of region had above national average and other with below national average. The region with the highest ratio is twice as high as the region with the lowest. The three regions with highest age dependency ratio are Simiyu (119.7), followed by Mara (113.2), Geita and Rukwa (112.9 each). The three regions with lowest age dependency ratio are Arusha (81.5) followed by Kilimanjaro (81.4) and Dar es Salaam (50.8).

The Tanzanian Demographic and Health Survey data of 2010 shows variation in Contraceptive Prevalence Rate (CPR) across the country whereas 35% of married women in the Tanzania mainland and 18% of married women in Zanzibar reported using any contraceptive method. The same was observed across Tanzania's regions (26 at that time). Pemba Island North has 7% of the married women and in Zanzibar South 33% of the married women who were currently using contraceptives. In Tanzania mainland, the region with the highest contraceptive use was Kilimanjaro region (65%) followed by Tanga region (54%). Mara was the region with the lowest contraceptive prevalence (12%) followed by its neighbours Mwanza region and Shinyanga region which had 15% each.

Therefore, the main objective of current study was to analyse the role of the family planning programme implementation process in explaining the observed geographical differences in CPR. The central research question for this study then is: *How is Tanzania's national family planning programme implemented, and can differences in implementation practices explain differences in CPR?*

Theoretical framework

The top-down approach was deployed to reconstruct the family planning programme implementation starting from the ministry level all the way down to the (potential) users of contraceptives (the clients). The aim of this investigation was to ascertain whether the implementation process moves along as designed at all levels. The bottom-up approach was used to assess the dynamics among street level bureaucrats at health facilities during the implementation of the programme in the health facilities. The aim was to determine if these street level bureaucrats apply coping strategies to deal with obstacles in the implementation. Tracing back to 1973 the top-down approach was introduced by Pressman and Wildavsky which was further developed by other scholars notably Van Meter and Van Horn (1975) who pioneered a top-down model of implementation with an emphasis on communication during implementation. It further developed by Mazmanien and Sabatier. However, other scholars such as Lipsky, Smith, and Hjern and Porter 1979 criticised the top-down approach and came up with another model that featured a bottom-up approach

From the empirical review, seven properties of programme implementation were derived, namely *adherence*, *exposure/dosage*, *quality of delivery*, *participant responsiveness*, *programme reach*, *adaptation* and *monitoring and control conditions*. Previous studies on implementation were limited to analysis of one property and lack attention to combining more than one property at once. Contrary, the seven properties were used to reconstruct the family planning programme implementation process from the ministry level to the end user (clients). For the purposes of this study, *implementation fidelity* will refer to three properties: *adherence, exposure/dosage* and *quality of services delivery*. The three properties selected are implementation fidelity in its real sense. The *participant/clients responsiveness* is the effect of the programme implementation. *Adaption* is a conscious breach of fidelity with the intention to be more effective i.e more fidelity concerning the goals of the programme. It is a divergence from protocols in order to realise programme goals. *Monitoring and control* is an additional feature to enhance implementation fidelity. *Adherence, exposure/dosage* and *quality of services delivery* are the effects and *monitoring and control,* and *adaptation* are conditions that influence fidelity. *Programme reach* is an output of the implementation fidelity.

To be able to study the family planning programme implementation process four specific research questions were developed. The formulation of these research questions was guided by the theoretical framework.

1. *How does the central government implement the family planning programme?*

The purpose of this question was to describe the implementation process of family planning programme at the central government. The proposition is that if the central government delivers the programme components equally in all LGAs, they would have the same level of CPR.

2. *How do the local government authority programme managers deliver the programme components in their areas?*

This question guided the reconstruction of family planning programme implementation at the LGAs. The reconstruction was focusing on the plans, targets and strategies formulated by these LGAs to implement the programme in the health facilities. The proposition is that the LGA's level of *adherence* with national guidelines is to be reflected in the LGA planning. In other words, a high level of LGA *adherence* will correspond with a high *quality* of services provided, which in turn produce a high CPR.

3. *How do the programme implementers (health providers) convey programme commodities and services to clients?*

The aim of this question was to describe how the street level bureaucrats (health workers) transform the policy and programme documents into actual services delivered to end users (clients). The assumption is that the better the LGA plans its family planning activities, the higher the implementation fidelity in the facilities. The second proposition the higher the implementation fidelity, the high the client responsiveness and CPR.

4. *What is the client responsiveness towards the family planning programme?*

The question seeks to establish the client responsiveness towards the health facility's family planning programme activities. It assumed that a positive reaction of the clients towards the programme is a prerequisite for the programme to realise its targets. The proposition is that a certain level of clients' responsiveness would correspond with a certain level of CPR.

The research questions, described above provide step-by-step parts of the answer to the broader question of this study. In the end it was possible to determine whether differences in family planning programme implementation practices explain regional and LGA differences in CPR.

Study design, data collection and analysis

The sources of data of this study were divided into two main parts: secondary data analysis and primary data collection. Secondary data analysis involved reconstructing how family planning issues are addressed in the National Population Policy, the National Family Planning Costed Implementation Programme (NFPCIP) 2010-2015 and the CCHP documents. The review assessed how and to which extent these documents addressed the core components of the family planning programme policy. Primary data were collected from a ministry official, the Regional Reproductive and Child Health coordinators (RCHco), the Regional Health Secretaries, the District Reproductive and Child Health coordinators (DRCHco), the District Health Secretaries and health workers providing family planning counselling and contraceptives. The interviews and observation were organised around the seven properties of programme implementation, i.e, *adherence, exposure, quality of services delivery, programme reach, adaptation, monitoring and control, and clients responsiveness* at the different levels.

The units of analysis in the study were the Ministry of Health and Social Welfare (MoHSW), Kilimanjaro region and Mara region. The data collection activity was conducted from May 2014 to February 2015. In this study, the central government was represented by the department of reproductive and child health of the Ministry of Health and Social Welfare, the region with the highest CPR (i.e. Kilimanjaro) and the region with the lowest CPR (i.e. Mara). Moreover, four local authorities (two from each region) were studied. These were Moshi MC and Moshi DC from Kilimanjaro region and Musoma MC and Musoma DC from Mara region. At the level closest to the client, two health centers from each local authority were selected: (i) Moshi municipal council: Majengo and Pasua health centers; (ii) Moshi DC: Kiruwa Vunjo and Himo health centers; (iii) Musoma MC: Nyasho and Bweri health centers; and (iv) Musoma DC: Murangi health center and Suguti Dispensary.

The content analysis was used to analyse the Tanzanian Population Policies, National Family Planning Costed Implementation Programme and Council Comprehensive Health Plan documents. With an assistant from Atlas.ti a narrative analysis was done to process stories collected in the in depth interviews, client exit interviews and during observations of services provision at health facilities. A phenomenological analysis was done to describe the providers' experience in family planning provisions, clients' experiences with services received; and provider and clients' behaviour noted during observation.

Descriptive statistics were used for presenting results from the quantitative data gathered from observation checklist. A *t-test* was performed to compare the mean differences for the two regions (Kilimanjaro and Mara) in *quality of services* provided to see if there were significant mean

differences. Furthermore, the analysis of variance (ANOVA) was done for the four local authorities, Moshi municipal council, Moshi DC, Musoma MC and Musoma DC for the *quality of services* provided. Lastly the analysis was done to examine the implementation factor(s) influencing the Contraceptive Prevalence Rate (CPR). The binary logistic regression was used for this purposes.

The key findings

This section summarises the key findings of the study. The findings are presented following the sequence of the chapters in a dissertation that follows the order of research questions.

Chapter 5, present results of the policy and programme documents analysis. The analysis was done to understand the core qualities of the policy and the programme as conceived and put into the document by the actor of that policy and programme. The first policy enacted in 1992 was focussing primarily on family planning. Its central goal was to raise the CPR although it did not state to what percentage. The revised policy of 2006 was far more developed than its predecessor, incorporating a wide range of relevant topics including development and stress on reproductive and child health where the family planning is integrated. The 2006 policy lacked clear targets, ways and means for achieving those targets. The NFPCIP was nevertheless clear in explaining the family planning programme and its goal to raise the CPR from 28% to 60% by 2015. It explicitly stated what should be done by whom and when to realise the stated goal.

Chapter 6, the results of primary data were presented, detailing the implementation process of family planning programme at the central government. The study findings indicate that the central government prepared different documents as guides for implementation of family planning programmes. It used different strategies to disseminate and distributes the produced documents. It conducted very little supervision in the areas under study. An expert wrote the different family planning documents but the ministry did the authorisation. NGOs organised most of the training sessions under approval of the ministry. The ministry did not actively participate in the dissemination and distribution of produced documents. The reason given was, that a lack of funds precluded the production of enough copies. The central government showed a high level of *adherence*, a low level of *exposure* and a low level of *monitoring of the control*.

Chapter 7's aim was to reconstruct family planning programme implementation by the LGAs. The reconstruction explores the plans, targets and strategies formulated by these LGAs to implement the family planning pro-

gramme. Training, drugs ordering and supervision; community outreach services; awareness and community acceptance; other organisations that provide family planning in the LGA and challenges perceived by managers and providers was another parameters examined. The finding shows that Moshi DC and Musoma DC did realise that there were low family planning prevalence rates in their jurisdictions. Both LGAs decided to include family planning in their CCHP and developed the strategies to raise CPR. Musoma MC too realised that the CPR was low though did not set any strategy to raise it. The Moshi MC did not write anything on family planning in their CCHP.

EngenderHealth, CEDHA and the ministry facilitated most of training conducted in the LGAs studied. The data showed that there were substantial differences between the Moshi municipal council, Moshi DC, Musoma MC and Musoma DC concerning the knowledge and skills of providers working in family planning unit across LGAs. Health providers working in family planning units in the Moshi MC and Moshi DC were trained in both short acting methods and long acting methods while those from Musoma MC were trained in short acting methods only. The situation was worsted in Musoma DC where in some of facilities family planning services were provided by medical attendants who did not even attend the nursing training. In Moshi Municipal council and Moshi DC all providers ordered the drugs themselves but in Musoma MC and Musoma DC some of the providers requested the drugs from the matron. The matron then ordered the supplies from MSD. Most of facilities would borrow from another facility within the LGA when they encountered a shortage of drugs. When the supplies in a LGA were depleted, attempts were made to borrow from other LGAs or to solicit supplies from NGOs.

With an exception of one facility from Musoma DC, the LGAs did not conduct family planning outreach services. What was usually done was requesting the NGOs to provide long acting methods, IUCD and Implants; and permanent methods (minilap) in their facilities. All LGAs conducted supervision every month. The conducted supervision was mainly mentoring and supportive supervision. In some LGAs the supervisions were postponed when the funds to facilitate these activities were lacking.

Chapter 8 provides an account of the findings on how the health workers at health facilities convey family planning programme commodities and services to clients. The research data show that the LGAs from Mara region had lower mean scores in all indicators of 'quality of services provided' than the LGAs from Kilimanjaro. There were observed changes in the Mara LGAs where the clients used more long acting methods than LGAs in Kilimanjaro. This might be contributed to a specific policy of the ministry and the NGOs aimed at the Lake Zone. Furthermore, the providers from Kilimanjaro LGAs provided more long acting methods compared to their counterparts from Mara's LGAs. This might be contributed to the qualifications of the provid-

ers. At Kilimanjaro all health workers working at family planning unit had been trained to provide long acting and short acting methods. At the Mara region most health workers active in family planning had attended training on the provision of short acting methods only.

Generally, the providers in the Kilimanjaro LGAs' facilities had a higher *dosage/exposure* of education and a higher *quality of services* provided than the workers of the Mara LGAs. The most obvious finding to emerge from this chapter is that there is a difference in *adherence* with procedures and standards that is reflected in the *quality* of family planning service provision across the LGAs. The *quality of services* provision is highest in Moshi DC; followed by Moshi municipal council, Musoma DC and the last LGA was Musoma MC. Although, the Musoma DC was the LGA that had the highest *programme reach* followed by Moshi MC and Musoma MC while the last one was Moshi DC. The specific experiences and competences of a provider caused her to have a specific coping strategy as an *adaptation* in the provision of the family planning services.

Chapter 9, provides insights into clients' responsiveness towards the family planning programme. The clients form Moshi MC and Moshi DC had both programme related factors and an intrinsic motivation towards the family planning programme. This was contrary to clients from Musoma MC and Musoma DC. The clients who received services in the facilities that had workers permanently assigned to the family planning unit were satisfied with the services received and waiting time. As they were assured that there was someone inside providing the services. These facilities were from Moshi MC and from Moshi DC. For those clients receiving the services in the facilities that did not have workers permanently assigned to the family planning unit were dissatisfied. This was at Musoma MC and Musoma DC.

Likewise, most of the clients received information concerning family planning more from relatives and friends than from the services providers. A one-pinpointed reason was that the health workers had multiple tasks that caused them to have less time to spend with clients. The clients at Musoma MC and Musoma DC had more fallacy on contraceptives than their counterpart from Moshi MC and Moshi DC. This chapter indicates that Moshi MC had the highest level of clients' responsiveness followed by Moshi DC, Musoma MC and the last LGA was Musoma DC.

Conclusion

The findings of this study show that there were indeed differences in implementation practices between Mara region with low level CPR and Kilimanjaro region with high CPR. These differences are largely attributed to differences in knowledge and skills of health workers working in family planning units. The family planning programme implementation was not intergovern-

mental, as hypothesised in chapter 3. Rather it was inter-professional. The NGO's make professional short cuts by directly training local staff in the guidelines and protocols, circumventing local planning activities. Even though the staff in the Mara LGAs did not make sure that the best trained staff was actually allocated at the family planning units doing the programme implementation. This training shortcut only works if the people who are trained are actually assigned as family planning providers. So the general answer to the question why there is such a difference in CPR is: because the Mara region LGAs do not employ properly trained providers. These findings suggest that in general the training (in implementing the guidelines), the role of the NGO's and quality of personnel are three components that loom large in explaining differences in implementation fidelity in facilities and thus in CPR.

Samenvatting

Inleiding

In 2012 had Tanzania een totale bevolkingsomvang van 44.928.923. Dit is vier keer zoveel als de bevolking in 1967 toen Tanzania 12.313.469 inwoners had. Verondersteld wordt dat de bevolkingsgroei te maken heeft met een hoge mate van vruchtbaarheid in combinatie met een afname van het sterfterisico. Momenteel is de vruchtbaarheidsindex stabiel 5,4. Dit is hoger dan het mondiale gemiddelde (2,4). En hoewel het sterfterisico daalt, is deze in Tanzania nog altijd relatief hoog: 81 op de 1.000 levend geboren kinderen sterft, terwijl dat mondiaal gemiddeld 37 is. Er is met name een verbetering opgetreden ten aanzien van het sterfterisico onder kinderen (jonger dan 5 jaar oud): 51 sterftegevallen op 1.000 geboortes, tegenover een mondiaal gemiddelde van 52 sterftegevallen op de 1.000 geboortes. De vooruitgang is met name geboekt ten aanzien van het sterfterisico van moeders. Deze is in Tanzania nog altijd 454 op 100.000 geboortes. Mondiaal is dat 210 op 100.000.

De cijfers blijken regionaal te verschillen. Sommige regio's zitten boven het gemiddelde, anderen eronder. De regio's met het hoogste sterftecijfer kent een cijfer dat tweemaal zo hoog is als de region met het laagste sterftecijfer.

Tegelijkertijd blijkt uit het Tanzaniaanse Demografie en Gezondheidsonderzoek uit 2010 een groot verschil in het gebruik van anticonceptie. De centrale overheid heeft beleid geformuleerd om het gebruik van anticonceptie te verhogen, juist gelet op de demografische consequenties (kinder- en kraamsterfte). Het doel van deze studie is te achterhalen wat de implementatie van het beleid ten aanzien van anticonceptie kan verklaren. De centrale onderzoeksvraag is derhalve: Hoe is het Tanzaniaanse beleid ten aanzien van het gebruik van anticonceptie geïmplementeerd en kunnen verschillen in implementatie het verschil in gebruik van anticonceptie verklaren?

Theorie

Om deze vraag te beantwoorden is een theorie geformuleerd, waarbij het centrale beleid als uitgangspunt is genomen. Dit beleid moet uiteindelijk worden geïmplementeerd door gebruikers (de cliënten). Het eerste onderdeel

van de theorie richt zich op de verwerking van het beleid door alle lagen van de overheid heen. Deze benadering is gebaseerd op het werk van Pressman en Widlavsky (1973)

Daarnaast is een bottom-up benadering gekozen. Deze benadering gaat uit van street level buraucrats die in de zorginstellingen de beleidsdoelen moeten realiseren. In deze benadering gaat het om de vraag hoe deze actoren met de belemmeringen van implementatie omgaan. Deze benadering past in de theorie die is ontwikkeld door Lipsky, Smith, en Hjern en Porter (1979).

Uit het literatuuroverzicht blijken zeven kenmerken van het beleidsprogramma relevant te zijn voor de implementatie: *adherence, exposure/dosage, quality of delivery, participant responsiveness, programme reach, adaptation en monitoring and control conditions*.

Deze kenmerken zijn vertaald naar het beleid ten aanzien van anticonceptie. Het gaat dan om het gedrag van de uiteindelijke cliënten.

Om de implementatie van het anticonceptiebeleid te bestuderen zijn vier onderzoeksvragen geformuleerd waarin deze kenmerken worden bestudeerd:

1. *Hoe implementeert de centrale overheid het anticonceptieprogramma?*
2. *Op welke manier geven de programma-managers in het lokaal bestuur gevolg aan het anticonceptiebeleid?*
3. *Op welke manier geven de zorgverleners invulling aan het beleidsprogramma bij de verlening van zorg aan de cliënten?*
4. *Wat is de reactie van de geadresseerde cliënten ten aanzien van dit beleid?*

Met beantwoording van deze empirische vragen wordt de implementatie van het beleid in kaart gebracht en kunnen mogelijke verschillen tussen regio's en districten worden verklaard.

Dataverzameling

Voor de beantwoording van de empirische vragen zijn secondaire en primaire bronnen gebruikt. De secondaire bronnen bestaan uit de bestudering van het beleid (de National Population Policy, de National Family Planning Costed Implementation Programme (NFPCIP) 2010-2015 en CCHP documenten). De bestudering is erop gericht om de doelen en middelen te achterhalen.

De primaire bronnen bestaan uit interviews met de Regional Reproductive and Child Health coordinatoren (RCHco), de Regional Health Secretaries, de District Reproductive and Child Health coordinators (DRCHco), de District Health Secretaries en met zorgverleners die advies moeten geven ten aanzien van anticonceptie. Daarnaast zijn observaties gedaan bij zorginstellingen.

Voor de studie zijn de regio's Kilimanjaro en Mara geselecteerd. In deze regio's zijn vier districten bestudeerd (twee in elke regio): Moshi District en Moshi Municipality, Mosuma District en Musuma Municipality. In deze districten zijn vervolgens steeds twee zorginstellingen geselecteerd om de implementatie door zorgverleners te achterhalen.

Bevindingen

Het eerste anticonceptiebeleid dateert van 1992, en was primair gericht op gezinsplanning. Het centrale doel was weliswaar het gebruik van anticonceptie te bevorderen, maar dit doel werd niet kwantitatief geformuleerd in een percentage. Het nieuwe beleid uit 2006 was verder ontwikkeld, en bevatte duidelijker doelen en middelen om die doelen te bereiken. Het doel in het beleid was om het gebruik van anticonceptie te verhogen van 28% naar 60% in 2015.

Ten aanzien van de implementatie van dit beleid blijkt dat de centrale overheid verschillende richtlijnen heeft afgegeven bedoeld ter ondersteuning van het implementatieproces. Tegelijkertijd is er weinig toezicht op de implementatie. Het verantwoordelijk ministerie blijkt niet actief bezig met de disseminatie van het beleid, bijvoorbeeld blijkend uit het feit dat er te weinig exemplaren van het beleid en de richtlijnen werden verspreid. De verklaring die werd gegeven was een gebrek aan financiële middelen. De conclusie ten aanzien van de implementatie is een hoge mate van *adherence*, maar een laag niveau van *exposure* en *monitoring and control*.

De volgende stap betreft de implementatie door de districten. Hiervoor zijn plannen van de districten beoordeeld. Uit deze plannen blijkt dat Moshi District en Musoma District de probleemanalyse onderschrijven. De plannen van deze districten bevatten middelen die ook in het centrale beleid werden voorgeschreven. Musoma Municipality onderschreef wel de beleidsanalyse, maar het plan bevatte geen instrumenten en Moshi Municipality had helemaal geen plannen ten aanzien van gezinsplanning.

Vervolgens is bestudeerd hoe zorgverleners met het beleid omgaan en in welke mate zij zich aan het beleid houden. Uit het onderzoek blijkt dat in Mara minder beleidsconform werd gehandeld dan in Kilimanjaro. Dit kan te maken hebben met specifiek landelijk beleid voor het merengebied, waarvan Mara deel uit maakt. In Kilimanjaro bleken alle zorgverleners getraind en op de hoogte van het beleid.

Ten slotte is nagegaan hoe de cliënten op het beleid reageren op het beleid. De cliënten in Moshi Municipal en Moshi District blijken een intrinsieke motivatie te hebben om zich aan het beleid te houden. Dit is in tegenstelling tot Musoma Municipal en Mosuma District. De meeste cliënten kregen wel de informatie over anticonceptie, vaak van kennissen en vrienden dan van de zorgverleners. Een reden was dat zorgverleners meerdere taken hadden en daardoor onvoldoende tijd hadden om deze specifieke taak te vervullen.

Conclusie

Uit de bevindingen kan worden afgeleid dat er inderdaad verschillen zijn in de mate van implementatie van het beleid tussen Mara en Kilimanjaro. Deze verschillen houden verband met een verschil in kennis en vaardigheden van de zorgverleners. Het blijkt dat de implementatie niet zozeer een kwestie is van interbestuurlijke verhoudingen, maar vooral van een professionele beïnvloeding van de zorgverleners. NGO's blijken buiten het beleid om de professionals te beïnvloeden met trainingsprogramma's en richtlijnen. In Mara blijkt het overheidsbeleid geen middelen te bevatten om zorgverleners te ondersteunen, maar worden deze zorgverleners ondersteund door NGO's.

Het antwoord op de centrale vraag is daarom dat het niet zozeer het beleid is dat leidt tot verandering in voorkeur ten aanzien van het gebruik van anticonceptie. De rol van NGO's blijkt van meer belang.

Annexes

Annex 1: List of articles

1. Africa: Support for family planning grows. (1978). *PP News, 1*(1), 5.
2. Agha, S., and Van Rossem, R. (2002). Impact of mass media campaigns on intentions to use the female condom in Tanzania. *International Family Planning Perspectives, 28*(3), 151-158.
3. Alex C. Ezeh, Blessing U. Mberu, and Jacques O. Emina. (2009) Stall in fertility decline in Eastern African countries: regional analysis of patterns, determinants and implications. *Phil Trans R Soc B 364(1532)* 2991-3007.
4. Ali, M. M., and Cleland, J. (2010). Oral contraceptive discontinuation and its aftermath in 19 developing countries. *Contraception, 81*(1), 22-29.
5. Angeles, G., Guilkey, D. K., and Mroz, T. A. (1998). Purposive programme placement and the estimation of family planning programme effects in Tanzania. *Journal of the American Statistical Association, 93*(443), 884-899.
6. Norris A., Prickett A., Beckham S., Harrington B., Hindin M. (2011). Overcoming barriers to contraceptive use in Zanzibar, Tanzania *Contraception, 84(3)*, 334.
7. Ayoub S. A, (2004). Effects of women's schooling on contraceptive use and fertility in Tanzania. *African population studies, 19(2)* 140-157.
8. Beegle, K. (1995). The quality and availability of family planning services and contraceptive use in Tanzania. *World Bank Living Standards Measurement Study Working Paper, 114*
9. Borgdorff, M. W., Barongo, L. R., Newell, J. N., Senkoro, K. P., Deville, W., Velema, P. J., et al. (1994). Sexual partner change and condom use among urban factory workers in northwest Tanzania. *Genitourinary Medicine, 70*(6), 378-383.
10. Bradley, J. E., Mayfield, M. V., Mehta, M. P., and Rukonge, A. (2002). Participatory evaluation of reproductive health care quality in developing countries. *Social Science and Medicine, 55*(2), 269-282.
11. Bunce, A., Guest, G., Searing, H., Frajzyngier, V., Riwa, P., Kanama, J., et al. (2007). Factors affecting vasectomy acceptability in Tanzania. *International Family Planning Perspectives, 33*(1), 13-21.
12. Bureau of Statistics [Tanzania] and Macro International Inc. 1997. *Trends in Demographic, Family Planning, and Health Indicators in Tanzania.* Calverton, Maryland: Bureau of Statistics and Macro International Inc.

13. Chintowa, P. (1988). UMATI: National family planning trainer. *Africa Link: A Publication of the Africa Region, 2*(2), 7-9.
14. Chitama, D., Baltussen, R., Ketting, E., Kamazima, S., Nswilla, A., and Mujinja, P. G. M. (2011). From papers to practices: District level priority setting processes and criteria for family planning, maternal, newborn and child health interventions in Tanzania. *BMC Women's Health,* 46.
15. Cohen, B. (1998). The emerging fertility transition in sub-Saharan Africa. *World Development, 26*(8), 1431-1461.
16. Condoms to be distributed to police, army and students, Tanzania. (1988). *CDC AIDS Weekly,* 11.
17. Creanga, A. A., Gillespie, D., Karklins, S., and Tsui, A. O. (2011). Low use of contraception among poor women in Africa: An equity issue. [Faible recours à la contraception chez les femmes africaines pauvres: Une question d'égalité] *Bulletin of the World Health Organisation, 89*(4), 258-266.
18. Damas S.R.M. Muna; Madale M. Mpamila, (2004). From fertility control to reproductive health and reproductive rights: implications of the Cairo and Beijing conferences in Tanzania. *Uongozi: Journal of Management Development, 16(1).*
19. Determinants of male fertility and sexual behaviour. A case for Mbeya and Rukwa regions of Tanzania. (1996). *CAFS News: A Centre for African Family Studies (CAFS) Newsletter, 6*(2), 9.
20. Dietrich J; Guilkey D; Mancini D, (1998). *Family planning, maternal/child health, and Sexually transmitted diseases in Tanzania: multivariate results using data from the 1996 demographic and health survey and service availability survey*. Chapel Hill, North Carolina, University of North Carolina at Chapel Hill, Carolina Population Center [CPC], MEASURE Evaluation.
21. Finger, W. R. (1995). Injectables use increasing rapidly. *Network, 15*(4), 20.
22. Gertig, D. M., Kapiga, S. H., Shao, J. F., and Hunter, D. J. (1997). Risk factors for sexually transmitted diseases among women attending family planning clinics in Dar-es-Salaam, Tanzania. *Genitourinary Medicine, 73*(1), 39-43.
23. GO-NGO collaboration in FP programmes. (1997). *Joicfp News,* (280), 4-5.
24. Goodyear, L., and McGinn, T. (1998). Emergency contraception among refugees and the displaced. *Journal of the American Medical Women's Association (1972), 53*(5 Suppl 2), 266-270.
25. Gorosh, M. E., Helbig, D. W., and Revson, J. E. (1980). Teaching family planning management and evaluation skills. *International Journal of Health Education, 23*(2), 107-115.
26. Hardee-cleaveland, K. (1992). Communication key for family planning. *Network, 13*(1), 13.
27. Hautvast, J., and De Jonge, K. (1972). Family limitation in rural Tanzania. *Tropical and Geographical Medicine, 24*(1), 91-94.

28. Hodgson, M. (1988). Training of family planning personnel. *Africa Link: A Publication of the Africa Region, 2*(2), 3-4.
29. Hotchkiss, D. R., Rous, J. J., Seiber, E. E., and Berruti, A. A. (2005). Is maternal and child health service use a causal gateway to subsequent contraceptive use?: A multi-country study. *Population Research and Policy Review, 24*(6), 543-571.
30. Hutchinson, P. L., Do, M., and Agha, S. (2011). Measuring client satisfaction and the quality of family planning services: A comparative analysis of public and private health facilities in Tanzania, Kenya and Ghana. *BMC Health Services Research, 11*
31. Hutchinson, P., and Wheeler, J. (2006). Advanced methods for evaluating the impact of family planning communication programmes: Evidence from Tanzania and Nepal. *Studies in Family Planning, 37*(3), 169-186.
32. Olenick I., (1998). In Tanzania, Ideal Family Sise Closely Resembles Actual Number of Children. *International Family Planning Perspectives,* 24(3) 147-149.
33. Jan Herman K., The implications of family planning in the changing socio-economic structure of the Nyakyusa, Rungwe district, Tanzania: seminar on population and economic growth in Africa, Leiden, 18-22 December, 1972.
34. Jato, M. N., Simbakalia, C., Tarasevich, J. M., Awasum, D. N., Kihinga, C. N. B., and Ngirwamungu, E. (1999). The impact of multimedia family planning promotion on the contraceptive behavior of women in Tanzania. *International Family Planning Perspectives, 25*(2), 60-67.
35. Kapiga, S. H., Hunter, D. J., and Nachtigal, G. (1992). Reproductive knowledge, and contraceptive awareness and practice among secondary school pupils in Bagamoyo and Dar-es-Salaam, Tanzania. *Central African Journal of Medicine, 38*(9), 375-380.
36. Kapiga, S. H., Lyamuya, E. F., Lwihula, G. K., and Hunter, D. J. (1998). The incidence of HIV infection among women using family planning methods in Dar es salaam, Tanzania. *AIDS, 12*(1), 75-84.
37. Kapiga, S. H., Vuylsteke, B., Lyamuya, E. F., Dallabetta, G., and Laga, M. (1998). Evaluation of sexually transmitted diseases diagnostic algorithms among family planning clients in Dar es Salaam, Tanzania. *Sexually Transmitted Infections, 74*(SUPPL. 1), S132-S138.
38. Keele, J. J., Forste, R., and Flake, D. F. (2005). Hearing native voices: Contraceptive use in Matemwe village, east Africa. *African Journal of Reproductive Health, 9*(1), 32-41.
39. Keogh, S. C., Urassa, M., Kumogola, Y., Mngara, J., and Zaba, B. (2009). Reproductive behaviour and HIV status of antenatal clients in northern Tanzania: Opportunities for family planning and preventing mother-to-child transmission integration. *AIDS, 23*(SUPPL. 1), S27-S35.
40. Kibuuka, H., Guwatudde, D., Kimutai, R., Maganga, L., Maboko, L., Watyema, C., et al. (2009). Contraceptive use in women enrolled into preventive HIV vaccine trials: Experience from a phase I/II trial in east africa. *PLoS ONE, 4*(4)

41. Krehbiel Keefe, S. (2006). 'Women do what they want': Islam and permanent contraception in northern Tanzania. *Social Science and Medicine, 63*(2), 418-429.
42. Larsen, U., and Hollos, M. (2003). Women's empowerment and fertility decline among the Pare of Kilimanjaro region, northern Tanzania. *Social Science and Medicine, 57*(6), 1099-1115.
43. Lugoe, W. L., Klepp, K. I., and Skutle, A. (1996). Sexual debut and predictors of condom use among secondary school students in Arusha, Tanzania. *AIDS Care - Psychological and Socio-Medical Aspects of AIDS/HIV, 8*(4), 443-452.
44. Madulu, N. F. (1995). Contraception prevalence under rural poverty: The case of the rural areas of Kondoa district, Tanzania. *Genus, 51*(1-2), 155-162.
45. Magoma et al. (2010), High ANC coverage and low skilled attendance in a rural Tanzanian district: a case for implementing a birth plan intervention. *BMC Pregnancy and Childbirth 10(13)*.
46. Mandara, N. A., Takulia, S., Kanyawana, J., and Mhalu, F. (1980). Asymptomatic gonorrhoea in women attending family planning clinics in Dar es Salaam, Tanzania. Results of a pilot study. *Tropical and Geographical Medicine, 32*(4), 329-332.
47. Marchant, T., Mushi, A. K., Nathan, R., Mukasa, O., Abdulla, S., Lengeler, C., et al. (2004). Planning a family: Priorities and concerns in rural Tanzania. *African Journal of Reproductive Health, 8*(2), 111-123.
48. Mary Arend-Skuenning and Flora l. Kessy (2007). The impact of demand factors, quality of care and access to facilities on contraceptive use in Tanzania. *Journal of Biosocial Science, 39(1)* 1-26
49. Mavanza, M., and Grossman, A. A. (2007). Conservation and family planning in Tanzania: The TACARE experience. *Population and Environment, 28*(4-5), 267-273.
50. M. W. Borgdorff, L. R. Barongo, J. N. Newell, K. P. Senkoro, W. Devillé, J. P. Velema, and R. M. Gabone, (1994). Sexual partner change and condom use among urban factory workers in northwest Tanzania. *Genitourinary Medicine, 70(6),* 378–383.
51. Mensch, B., Fisher, A., Askew, I., and Ajayi, A. (1994). Using situation analysis data to assess the functioning of family planning clinics in Nigeria, Tanzania, and Zimbabwe. *Studies in Family Planning, 25*(1), 18-31.
52. Mnyika, K. S., Klepp, K. -., Kvale, G., and Ole-King'ori, N. (1997). Determinants of high-risk sexual behavior and condom use among adults in the Arusha region, Tanzania. *International Journal of STD and AIDS, 8*(3), 176-183.
53. Mnyika, K. S., Klepp, K. -., Kvale, G., Schreiner, A., and Seha, A. M. (1995). Condom awareness and use in the Arusha and Kilimanjaro regions, Tanzania: A population-based study. *AIDS Education and Prevention, 7*(5), 403-414.
54. Mnyika, K. S., Kvale, G., and Klepp, K. I. (1995). Perceived function of and barriers to condom use in Arusha and Kilimanjaro regions of Tanza-

nia. *AIDS Care - Psychological and Socio-Medical Aspects of AIDS/HIV, 7*(3), 295-305.
55. Morof DF, Atwine B, Luguku G, Purdin S. Refugee family planning: User profiles from Mtendeli refugee camp in Kibondo, Tanzania. *Contraception. 2007; 76(2):* 175.
56. Mpangile, G. S. (1988). Summary of the third national workshop of the integrated family planning, nutrition and parasite control project. *Integration (Tokyo, Japan),* (18), 42-44.
57. Mpangile, G. S. (1991). 6.7% practice family planning. Findings of a baseline survey of knowledge, attitudes and practice in a Tanzanian village. *Integration (Tokyo, Japan),* (30), 34-37.
58. Mroz, T. A., Bollen, K. A., Speiser, I. S., and Mancini, D. J. (1999). Quality, accessibility, and contraceptive use in rural Tanzania. *Demography, 36*(1), 23-40
59. Msofe, Grace E.P Kiondo, Elizabeth. (2009). Accessibility and use of family planning information (FPI) by rural people in Kilombero District. *Africa Journal of Library, Achives and Information Science 19(2),* 117-127.
60. Mtawali, G., Muhuhu, P., Angle, M., and Lea, J. (1990). Pregnancy diagnosis and contraception. *Africa Health, 13*(1), 36-37.
61. Mturi, A. J., and Hinde, P. R. A. (1994). Fertility decline in Tanzania. *Journal of Biosocial Science, 26*(4), 529-538.
62. Murty, J. (1998). Introduction of gynefix as a choice in reproductive health care. *British Journal of Family Planning, 24*(2), 87.
63. Mwageni, E. A., Ankomah, A., and Powell, R. A. (1998). Attitudes of men towards family planning in Mbeya region, Tanzania: A rural-urban comparison of qualitative data. *Journal of Biosocial Science, 30*(3), 381-392.
64. Ngadaya, E. S., Mfinanga, G. S., Wandwalo, E. R., and Morkve, O. (2009). Pulmonary tuberculosis among women with cough attending clinics for family planning and maternal and child health in dar es salaam, tanzania. *BMC Public Health, 9*
65. Nguyen, H., Snider, J., Ravishankar, N., and Magvanjav, O. (2011). Assessing public and private sector contributions in reproductive health financing and utilisation for six sub-Saharan African countries. *Reproductive Health Matters, 19*(37), 62-74.
66. Nyong'o, D. (1996). Generating public awareness in Africa. Advocacy for reproductive health: Africa. *Planned Parenthood Challenges / International Planned Parenthood Federation,* (1), 2-4.
67. Omari C. K. (1989), *Socio-cultural factors in modern family planning methods in Tanzania*, Lewiston N.Y. [etc.]: Edwin Mellen Press.
68. Omari, C. K. (1988). Modern family planning, sexual behavior and marriage status among women in Tanzania. *International Journal of Sociology of the Family, 18*(1), 1-14.
69. On the efficiency of multiple media family planning promotion campaigns. (1999). *Africa's Population and Development Bulletin,* 18-19.

70. Pile, J. M., and Simbakalia, C. 2006. *Repositioning family planning—Tanzania case study: A successful programme loses momentum.* New York: Engender Health/The ACQUIRE Project.
71. Plummer, M. L., Wight, D., Wamoyi, J., Mshana, G., Hayes, R. J., and Ross, D. A. (2006). Farming with your hoe in a sack: Condom attitudes, access, and use in rural Tanzania. *Studies in Family Planning, 37*(1), 29-40.
72. Popoola, D. (1999). Involving men in reproductive health advocacy in the united republic of Tanzania. *Promotion and Education, 6*(2), 20-23, 39, 50-51.
73. Popular soap opera helps raise contraceptive use. Tanzania. (1996). *Integration (Tokyo, Japan),* (47), 41.
74. Population policies gain momentum among African countries. (1992). *African Population Newsletter,* (62), 5-6.
75. Rasch, V., and Lyaruu, M. A. (2005). Unsafe abortion in Tanzania and the need for involving men in post abortion contraceptive counseling. *Studies in Family Planning, 36*(4), 301-310.
76. Rasch, V., Yambesi, F., and Kipingili, R. (2005). Scaling up post abortion contraceptive service - results from a study conducted among women having unwanted pregnancies in urban and rural Tanzania. *Contraception, 72*(5), 377-382.
77. Rasch, V., Yambesi, F., and Massawe, S. (2008). Medium and long-term adherence to post abortion contraception among women having experienced unsafe abortion in Dar es Salaam, Tanzania. *BMC Pregnancy and Childbirth, 8*
78. Renewed commitment. Reaffirmed collaboration. UNFPA and JOICFP strengthen and expand collaboration in field of population and reproductive health / family planning. (1996). *Joicfp News,* (269),
79. Richey, L. (1999). Family planning and the politics of population in Tanzania: International to local discourse. *Journal of Modern African Studies, 37*(3), 457-487.
80. Richey, L. A. (2002). Is over-population still the problem? Global discourse and reproductive health challenges in the time of HIV/AIDS. *CDR Working Paper, 2*(1), 1-21.
81. Richey, L. A. (2004). Construction, control and family planning in Tanzania: some bodies the same and some bodies different. *Feminist Review, 78,* 56–79.
82. Richey, L. A. (2008). Global knowledge/local bodies: Family planning service providers' interpretations of contraceptive knowledge(s). *Demographic Research, 18*, 469-498.
83. Richey, L. A. (2008). Population politics and development: from the policies to the clinics; Palgrave Macmillan: New York.
84. Rogers, E. M., Vaughan, P. W., Swalehe, R. M. A., Rao, N., Svenkerud, P., and Sood, S. (1999). Effects of an entertainment-education radio soap opera on family planning behavior in Tanzania. *Studies in Family Planning, 30*(3), 193-211.

85. Saidi H. K, Eligius F. L,. Bea V., Donna S., Ulla L., David J. H., (2000). Risk Factors for HIV-1 Seroprevalence among Family Planning Clients in Dar es Salaam, Tanzania. *African Journal of Reproductive Health.* 4(1), 88-99.
86. Saumya R. and Raji M. (2003). The Quality of Family Planning Programmes: Concepts, Measurements, Interventions, and Effects. Studies in Family Planning, 34(4), 227-248.
87. Scribner, S. (1995). Policies affecting fertility and contraceptive use: An assessment of twelve sub-Saharan countries. *World Bank Discussion Papers, 259*
88. Speiser, I. S., and Bollen, K. A. (2000). How well do perceptions of family planning service quality correspond to objective measures? Evidence from Tanzania. *Studies in Family Planning, 31*(2), 163-177.
89. Speiser, I. S., Hotchkiss, D. R., Magnani, R. J., Hubbard, B., and Nelson, K. (2000). Do service providers in Tanzania unnecessarily restrict clients' access to contraceptive methods? *International Family Planning Perspectives, 26*(4), 13-20.
90. Steep increase in contraceptive use in Tanzania. (1995). *Newsletter (Macro Systems. Institute for Resource Development. Demographic and Health Surveys), 7*(2), 8.
91. Stein, K. (1996). Service quality among women receiving MCH and family planning services. *African Journal of Fertility, Sexuality, and Reproductive Health, 1*(2), 146-152.
92. Stein, K. (1998). Using situation analysis to assess women's perception of quality of maternal-child health and family planning services. *Reproductive Health Matters, 6*(11), 45-54.
93. Steve C. and Nyovani M,. (2004). Who Is Being Served Least by Family Planning Providers? A Study of Modern Contraceptive Use in Ghana, Tanzania and Zimbabwe. African Journal of Reproductive Health, 8(2), 124-136.
94. Susan C. and David K. G,. (2003). Determinants of Contraceptive Method Choice in Rural Tanzania between 1991 and 1999. *Studies in Family Planning, 34(4)* 263-276.
95. Sunil M. and Maggie B. (1979). 'THE DECISION MAKERS': *What the people of India, Tanzania and Bangladesh have to say about family planning.* New internationalist: the people, the ideas, the action in the fight for world development.
96. Twaha, A.L.A. (2002). *Exploring Unmet Need for Family Planning Services in Tanga, Tanzania*, Royal tropical institute (KIT): Amsterdam.
97. Wegner, M. N. (1996). Men and reproductive health. *AVSC News (Association for Voluntary Surgical Contraception (U.S.)), 34*(4), 2.
98. What some African development plans say on population related issues in development. (1983). *African Population Newsletter,* (44-45), 9-17.
99. Yeager, R. (1982). Demography and development policy in Tanzania. *Journal of Developing Areas, 16*(4), 489-510.

100. Z. Mgalla and R. Pool (1997): Sexual relationships, condom use and risk perception among female bar workers in north-west Tanzania, AIDS Care: *Psychological and Socio-medical Aspects of AIDS/HIV*, 9(4), 407-416

Annex 2: Regression coefficients for individual-level characteristics (model I)

Variables	Beta	P-value.
Current age of respondent	-0.005	0.729
Total children ever born	0.147	0.001
Type of place of residence		
Urban (Ref)		
Rural	-0.474	0.030
Woman's educational level		
No education (Ref)		
Primary education	-0.011	0.956
Secondary education and above	0.038	0.901
Woman' occupation		
Not working, unskilled manual (Ref)		
Professor technician, manager, clerical, services	0.828	0.011
Agricultural self employed, household and domestic	0.111	0.586
Agricultural employee, skilled manual	0.481	0.158
Household wealth index		
Poorer (Ref)		
Middle	0.343	0.093
Richer	0.768	0.000
Ideal number of children	-0.012	0.104
Sex of household head		
Male (Ref)		
Female	0.191	0.544
Final say on own health		
Alone (Ref)		
Respondent and husband/partner	0.018	0.936
Husband/partner alone/someone else	-0.070	0.755
Person to talk to most about family planning		
Husband/partner alone (Ref)		
Community-based distribution worker and clinic staff	0.350	0.072
Friend, relative and religious leaders	0.171	0.716
Partner's (husband's) education		
No education (Ref)		
Primary education	0.396	0.110
Secondary education and above	0.514	0.118
Partner's (husband's) occupation		
Not working, Unskilled manual (Ref)		
Professor technician, manager, clerical, services	-0.361	0.228
Agricultural self employed, household and domestic	-0.269	0.278
Agricultural employee, skilled manual	-0.171	0.543

Annex 3: Interview and observation guide.

A: Interview Guide for Regional and District Reproductive and Child Health coordinators (Supervisor), and Reproductive and Child Health in charge at Health Facilities

Supervisors/In charges

1. How do your **(Select appropriate option… region/district/health facility)** identify the training needs in FP? Probe: How many have been trained?
2. What are the contents of attended training?
3. How do the supervisors from (**Ministry/region/district)** conduct the supervision process?
4. How do you conduct the supervision process? Probe: How many times you did for last year (2013/2014)?
5. How do you monitor the activities of your provider? Probe: How many times for the last year (2013/2014)? What are the output and outcome for each session?
6. How do you evaluate the progress of family planning services in your (**region/district/health facility)?** Probe: How many times for last year (2013)? What are the output and outcome for each session?
7. How does your office use the information/statistics obtained from monitoring and evaluation?
8. What steps do you follow in ordering FP commodities and supplies? Probe: What were the outcomes for each order? How do you address them?
9. How does your office **(District/health facilities)** conduct the community outreach? Probe: What procedure used, Number of outreach, and who was involved?
10. What were your targets for FP services provision last year? Probe: Did you realise them?
11. What strategies did you use to realise **(above/below)** targets? Probe: Did you have any obstacles?

Observation Guide

Section I. Interpersonal relations and routine procedures

How does the provider interact with clients? **Observe:** See client in private; Greet client; Assure confidentiality to client; Review client's previous records; Ask number of previous visits; Ask open-ended questions; Encourage client to ask questions; Treat client with respect; Use IEC materials; Give client IEC reading material (if available and appropriate); Discuss return visit.

Section II. Family Planning

1. What is the reason for the present visit: How does the provider probe client about the reason for visit? **Observe:** asking on information and counselling only; Continuing client (using same method/follow-up visit); New client or changed contraceptive method; Abortion/post-abortion care.

2. The provider discusses the following historical information with the client? **Observe:** Current age; Marital status; Number of living children; Last delivery date; Age of youngest child; Total number of pregnancies; Desire for more children (Want more?); Timing of next child (When?); Current pregnancy status; History of pregnancy complications; Partner attitude about family planning; Client breastfeeding (history); Past family planning use; Date of last menstrual period; Regularity of menstrual cycle.

3. How did the provider conduct the counselling and education: **Observe:** Discuss range of methods available at facilities; Help client to choose appropriate method (short term, long term, or permanent); Discuss client's method preference; Discuss effectiveness of method; Discuss how to use method; Discuss side effects of method; Discuss advantages of method; Discuss disadvantages of method; Tell client what to do if experiences problems with method; Give method of choice or refer client for method of choice.

4. How did the provider do the following care to clients: **Observe:** Check blood pressure; Check/ask about pregnancy; Ask about smoking; Ask about chronic health problems; Check body weight; Ask about allergies to latex; Ask about pelvic pain; Ask about vaginal discharge.

5. What is the type of contraceptive method and services client received? **Observe:** Combined Oral Contraceptive (COC) Pill; Progesterone-only Pill (POP); Depo Provera; Condom; Emergency Contraception; Counselling only, no method received; referred for a method higher level health facility (IUD, Tubal ligation)

Note: The observations check list was created (see table 4.4 in text) to assess the presence or absence of the description stated above. The how part was addressed by writing the memo on each observation in relation to the way provider handle the client. The narration will assess whether the provider handle the client in, kindness, harry, taking time to listen the clients, harshness, humble, calm, or politely.

Section III: Client Acceptance of the Methods

What is the reaction of client after the consultation with service provider? **Observe:** Client reaction

C: Interview guide for Service provider

1. Facility Identification
Name of the facility……
Location of the facility: District ……. Region…….….

2. Information About Observation
Date……
Provider code…….
Sex of Client……

1. What type of training have you received? Probe: Before working in this unity, after start working in this unity? (Types of training, area covered, usefulness of training in present job).
2. How many supervisor(s) do you have? Do you have any conversations with your supervisor(s)? Probe: what information do you get from your supervisors? Types of interactions; Supportive supervision, coaching, mentoring.
3. Tell me on the working environment! How do you describe the FP infrastructure? Probe: Do you have special room (building) for provision of family planning services? Enough space? Room for different FP services provided? How does Management support the provision of FP (material wise and moral support)? Are they in favour of FP?
4. Can you tell me your experience in family planning provision in this facility? Probe: Availability of contraception, Equipment used in services delivery (gauze, examination light, gloves, antiseptics etc), and ICE (education material).
5. What tools do you use to guide you in provision of family planning services? Probe: ICE materials, different documents, guideline, protocols and procedure manual.
6. What do you do when the unit has a lot of clients who you cannot serve yourself? Probe: Ask for support? Get support from other worker? Send people away? Creating the waiting list? Shorten the consultation?
7. Can you tell me your relationship with (**mention one by one):** co-worker, manager, client and community at large) in this facility?
8. Does your supervisor talk with you about issue related to quality of consultation you provide? Probe: What s/he usually discusses with you?
9. What information do you often receive from (**mention one after another)**: supervisors, other service providers and client? Probe: Feedback on supervision, material requested, quality of services and type of services provided.
10. How do your supervisors treat you? Probe: During decision-making process? Requesting new information, family planning commodities and supplies?

Thank you very much for taking the time to answer my questions. Once again, any information you have given will be kept completely confidential.

Have a good day!

D: Exit Interview for Family Planning Client

1. Can you tell me about your history with this health facility? **(Mention the name)** Probe: Have you ever been to this clinic before? Receiving family planning services?
2. Have you ever been pregnant? What method or steps do you use to prevent Pregnancy? Probe: for how long you have used it? What was the last method you used? Did the provider ask you today whether you were having (or

had) a problem with the method? Did you have any problem with the method? Did the provider suggest any action(s) you should take to resolve the problem?

3. What was the outcome of this visit? Probe: did you decide to continue with **(restart)** the same method? Switch methods? Stop using method?
4. Why did you use the mentioned method or thought about changing methods? Probe: Which method you thought changing to? Did the provider tell you about any of the method(s) you just mentioned? What **(other)** family planning methods did the provider talk about? What family planning method did you either receive or get a prescription or referral for?
5. During your consultation, did the provider explain how to use the method? Probe: Talk about possible side effects? Tell you what to do if you have any problems? Tell you when to return for follow-up? How often do you should take the pill?
6. How do you assess the waiting time between the time you arrived at this facility and the time you were able to see a provider for the consultation?
7. How do you see the ability of provider to discuss problems or concerns about your health? Probe: Amount of explanation you received about any problem or method of family planning?
8. How does the staff (provider) treat you? Probe: consultation process (welcoming face, gestures), examination and procedure performed. Privacy from having others sees the examination. Privacy from having others hear your consultation discussion.
9. What was the main reason for you to use this facility? Probe: Closest health facility to your home? Visited this facility before (either as a patient or visiting or accompanying a patient)? Referred by relatives and friends?

Now I am going to ask you some questions about yourself.

1. How old were you at your last birthday?
2. Age in years . . . .
3. What is the highest level of school you attended?
4. What do you do for the living?
5. How many children do you have?
6. What is your marital status?

Interview Guide (Swahili translation)

A: Supervisors/In charges

1 Ni jinsi gani **(Mkoa/wilaya/kituo cha afya wako/chako)** unavyotambua uhitaji wa mafunzo juu ya Uzazi wa mpango? Probe: Ni wafanyakazi wangapi wamefundishwa?

2 Wamefundishwa kwenye maeneo yapi?

3 Ni namna gani supervisor kutoka (**Wizarani/mkoani/wilayani**) wanafanya supervision?

4 Unafanyaje supervision? Probe: Umefanya ngapi kwa mwaka uliopita (2013/2014)?

5 Unamonitor vipi kazi zinazofanywa na watoa huduma? Probe: Umefanya monitoring ngapi kwa mwaka Jana (2013/2014)? Ni maotokeo gani yamepatikana kutoka kwenye kila session?

6 Unatathimini vipi maendeleo ya huduma za uzazi wa mpango katika (**mkoa/wilaya/kituo**) wako/yako/chako? Umefanya mara ngapi mwaka jana? Ulipata matokeo gani kwenye kila tadhimini?

7 Ni jinsi gani ofisi yako inatumia taarifa/takwimu zinazokusanywa kwenye monitoring na evaluation?

8 Unafanyaje wakati unapotoa order ya bidhaa za uzazi wa mpango na bidhaa zingine zinazohusiana na uzazi wa mpango? Probe: Ulipata matokeo/majibu gani kwenye kila order kwa mwaka uliopita? Ulifanyaje kutatua matokeo/majibu uliyoyapata?

9 Ni namna gani ofisi yako inafanya community outreach kuhusiana na uzazi wa mpango?
Probe: Unatumia utaratibu gani? Umefanya outreach ngapi kwa mwaka jana? Watu gani walihusika (kutoka hapa ofisini na walengwa)

10 Ulikuwa na malengo gani kwa ajili ya uzazi wa mpango kwa mwaka jana? Ulifikia malengo uliyojiwekea?

11 Ulitumia mikakati gani kufikia malengo (Juu/chini) Probe: Ulikumbana na vikwazo vyovyote?

B: Interview guide for Service provider

1. Umepata mafunzo gani? Probe: Kabla hujaanza kufanya kazi kwenye hiki kitengo? Baada ya kuanza kufanya kazi kwenye hiki kitengo (aina ya mafunzo, eneo ulilofundishwa, umuhimu na matumizi ya elimu uliyoipata kwenye kazi unayofanya sasa)
2. Una masupervisor wangapi? Una mazoea ya kuongea nao? Probe: Unapata taarifa gani kutoka kwao? Uhusiano wenu ni wa namna gani? Kujadiliana, kufundishana, kupewa maelekezo, kusaidiwa kwa vitendo pale unaposhidwa n.k
3. Naomba unieleze kuhusiana na mazingira ya kufanyia kazi! Unazungumziaje mazingira ya kutolea huduma za uzazi wa mpango? Probe: Mna jengo maalum (chumba) la kutolea huduma za uzazi wa mpango? Eneo linatosha? Mna vyumba vya huduma mbalimbali za uzazi wa mpango? Ni jinsi gani uongozi wa hiki kituo/wilaya unavyowasaidia kwenye utoaji wa huduma za uzazi wa mpango (kwa vifaa au kuwatia moyo)? Kwa mtizamo wako wanapenda uzazi wa mpango?
4. Unaweza kunieleza uzoefu wako kwenye utoaji wa huduma za uzazi wa mpango kwenye hiki kituo? Probe: Upatikanaji wa njia za uzazi wa mpango? Vifaa vinavyotumika kwenye kutoa uzazi wa mpango kama gauze, examination lamp, gloves, antiseptic, ICE material na vinginevyo?
5. Unatumia tool gani kukusaidia wewe kwenye utoaji wa huduma za uzazi wa mpango? Probe: ICE material, guideline, procedure manual.
6. Unafanya nini idara yako inapokuwa na wateja wengi ambao huwezi kuwahu-

dumia peke yako? Probe: unaomba msaada? Unapata msaada kutoka kwa wenzako? Unawaambia watu waondoke waje wakati mwingine? Au unafupisha mda wa kutoa huduma ili uwaone watu wengi zaidi?

7. Naomba unieleza uhusiano wako na **(wafanyakazi wenzako, wakuu wa idara na kituo, wateja na jamii kwa ujumla wake**) kwenye hiki kituo?
8. Je supervisor wako wanaongea na wewe kuhusiana na ubora wa huduma za uzazi wa mpango unazotoa? Probe: Ni vitu gani huwa mnajadiliana mara nyingi?
9. Ni taarifa gani unapata mara kwa mara kutoka kwa (supervisor, wafanyakazi wenzako, na wateja? Probe: Feedback ya supervision, vifaa ulivyoomba, ubora wa huduma, na aina ya huduma unazotoa?
10. Supervisor wako anakuchukuliaje? Probe: wakati wa kutoa maamuzi? Kuomba taarifa mpya? Kuomba bidhaa za uzazi wa mpango na bidhaa zingine?

Asante sana kwa mda wako. Nakuatakia mafanikio kwenye kazi zako za kila siku.

C: Exit Interview for Family Planning Client

1. Unaweza kunieleza historia yako na kituo hiki (**Kitaje**)? Probe: Ulishawahi kuwa kwenye hiki kituo kabla ya sasa? Ulikuja kufanya nini? Kupata huduma za uzazi wa mpango?
2. Umeshawahi kuwa mjamzito? Ulikuwa unatumia hatua zipi kujilinda usipate ujauzito? Probe: Umetumia kwa mda gani? Ulikuwa unatumia njia gani? Je mhudumu alikuuliza swali lolote kama ulipata matatizo na njia uliyokuwa unatumia? Je una matatizo yeyote uliyopata ulipokuwa unatumia hiyo njia? Mhudumu alikuelekeza njia utakayofanya kwa kuondoa matatizo yaliyojitokeza?
3. Umepata mafanikio gani kwa mahudhurio ya leo? Probe: Umeamua kuendelea na njia uliyokuwa unatumia? Kubadili njia? Au kuacha kabisa kutumia?
4. Kwa nini umeamua kutumia njia uliyonitajia/Kwa nini umeafikiria kubadilisha njia? Probe: Umeahamia kwenye njia gani? Je mhudumu aliongea na wewe kuhusu njia uliyonieleza? Ni njia gani za uzazi wa mpango mhudumu aliongea na wewe? Umepewa dawa gani ya uzazi wa mpango/umeandikiwa rufaa ya kwenda kupata njia gani?
5. Wakati ukipewa huduma je mhudumu alikuelekeza jinsi ya kutumia njia uliyochagua? Probe: Alikueleza kuhusu madhara yanayoweza kutokea? Unatumia vidonge mara ngapi kwa siku?
6. Unatoa tathimini ipi kwa muda uliosubiri toka ufike hapa kituoni na mda ulioweza kupewa huduma? Probe: umekaa sana? Umekaa kidogo?
7. Unaonaje uwezo wa wahudumu/mhudumu kujadili matatizo au huduma inayohusu afya yako? Probe: Wingi wa maelekezo uliyopata kuhusiana na suala lolote la kiafya au linalohusiana na njia unayotumia?
8. Wahudumu walikuhudumiaje? Probe: Ubora wa mahojiano, uchunguzi uliofanyika, huduma uliyopewa, usiri wa huduma zenyewe wengine wasikuone, usiri wa watu wengine kusikia unachoongea na mhudumu.

9. Ni kitu gani kikubwa kimekufanya utumie kituo hiki cha afya? Probe: Kiko karibu na nyumbani? Ulishawahi kuja kwenye hiki kituo aidha ukiwa mgonywa wa kawaida au kumleta mgonywa.

Sasa naomba nikuulize maswali yanayokuhusu wewe mwenyewe

1 Ulikuwa na miaka mingapi uliposherehekea birthday yako?
2 Kwa hiyo una miaka mingapi sasa?
3 Una kiwango gani cha elimu?
4 Unafanya kazi gani?
5 Una watoto wangapi?
6 Umeolewa/umewahi kuolewa?

Asante sana kwa kunisikiliza na kuchukua mda wako kujibu maswali yangu. Kwa mara nyingine tena na kuhakikishia majibu uliyonipa yatakuwa ni siri kubwa na hakuna mtu yeyote atakayeweza kuyaona. Nakutakia siku njema.

Curriculum Vitae

Mackfallen Giliadi Anasel holds a Bachelor of Public Administration, Health Systems Management from Mzumbe University (Tanzania) and a Master of Science in Population Studies from Groningen University (the Netherlands). Since 2008 he has been working with Mzumbe University, School of Public Administration and Management – Department of Health Systems Management as a Lecturer.